

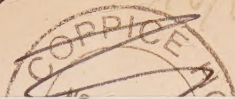
TREATMENT
OF THE
NEUROSES
BRADST. JONES



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TREATMENT OF THE NEUROSES

BY

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PREFACE

IT being evident that the treatment of the neuroses is now engaging the interest of the medical profession to an extent never before approached, this has seemed an appropriate moment to publish a review of the various methods of treatment at our disposal, and, as the writer is in the peculiar position—at all events in this country—of having had a considerable experience with all the main methods, he has regarded it as a duty to undertake this task. The attempt has been made to lay stress on the positive aspects of each method, *i.e.* on the contribution they may have made to our knowledge or capacity to help, rather than on the negative ones, though a critical summary has been added in each case. Further, as many of the principles of treatment would have been unintelligible without reference to the theory on which they are based, it has been necessary to say something on the subject of pathology, and even, here and there, on that of symptomatology, the space devoted to these matters, however, having been reduced to a minimum. To avoid needless repetition the principles of psychopathology and of mental therapeutics have been dealt with at some length under one heading, the appropriate one of hysteria, so that the chapters on the other neuroses are correspondingly short. The selection of the Bibliography has been determined by the intrinsic merit of the work to which reference is made, by its function as

a representative of a given school of thought, or by its usefulness as a source of references for further reading.

A part of this volume appeared in a section devoted to the subject in White and Jelliffe's encyclopædia entitled "The Modern Treatment of Nervous and Mental Diseases," but it has been re-arranged, re-written, and extensively added to ; the author wishes to express his indebtedness to the editors and publishers of that book for their kind permission to make use of the section.

111, HARLEY STREET,
LONDON,
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TREATMENT OF THE NEUROSES

CHAPTER I

INTRODUCTION

GENERAL IMPORTANCE

THAT the study and treatment of the neuroses constitute one of the most responsible tasks allotted to the medical profession becomes manifest from the following considerations :—

I. Significance of Neurotic Suffering.—The suffering that may be caused by a neurosis has certain peculiarly distressing features, the significance of which is often not appreciated by the observer. Being most frequently of a directly mental order, it disturbs the very centre of the personality. With the most grievous forms of bodily suffering, even with the pains of cancer or the suffocation of thoracic disease, the patient at least preserves his mind relatively intact. In even the worst moments he has some sanctuary into which he may withdraw, and where it is possible to have recourse to consoling thoughts, memories and reflections ; the affliction can to some extent be met, and commonly is met, by the philosophy or religion that the experience

of life has built up. With a neurosis, on the other hand, the sufferer is robbed of this last resource. The very organ that yields consolation, that philosophises, is no longer whole, for it is the mind itself whose functions, are impaired; his inmost being is deranged, and he dimly realises that it is being torn by the conflicts warring in the recesses of his mind. A common cry of such patients, especially of those plagued by obsessional or anxiety disorders, is that they might forget themselves, get away from themselves, and have at all events a few moments of mental peace; when insomnia sets in, as is so often the case, even the respite of sleep is denied them, or sleep itself may be so broken by fearful dreams that it comes to be dreaded as one of the worst of miseries. The patient's mental anguish may in many cases be so intense, and his internal support so little to be relied on, that he is seized with the conviction that the worst is about to happen and that he is rapidly becoming insane—a consummation looked to with the utmost terror.

Added to these considerations is the circumstance that, in spite of the special need for it, there is hardly any malady that receives so little understanding or even common sympathy as does a neurosis. This applies not only to the relatives and friends, but often enough to the medical practitioner as well. One of the reasons for it is the great difficulty that most patients experience in communicating any adequate description of their state of mind to those about them, a difficulty only partly due to the foreignness of this state from anything with which the normal person is familiar. A neurotic illness is vaguely felt to have something essentially unreal about it,

to contain something of a pose—for instance, a “craving for sympathy,” and to be much more under the control of the patient’s will than he can be got to admit. The old theological conception of disease, as being either a manifestation of sin or a punishment for sin—at all events something for which the individual is ultimately responsible—has shewn itself far more tenacious of existence here than elsewhere in medicine. It is well indicated in the popular view that the patient could do better “if he would only try,” that like Dickens’s Mrs. Dombey he is collapsing merely for lack of “making an effort,” that he wilfully refuses to take his mind away from himself and his symptoms, and that substantially he is suffering from either deliberate perversity or capricious failure to use the will-power and self-control at his command.

This view is also mirrored, though usually in a more veiled form, in many medical treatises on the subject,* and indeed comes to expression in the very language used ; writers speak, for example, not of making a diagnosis of hysteria, but of “detecting” it, various signs are said to indicate “malingering or hysteria” in a tone that leaves it doubtful whether the two terms are synonymous or supplementary, and an author’s attempt to salve his medical conscience by appending to a moral homily on

* Thus F. T. Roberts, in his compendious “Theory and Practice of Medicine,” gives a long list of “causes” of hysteria—from “keeping late hours at parties” to “senile degeneration”—and, apparently conscious of his failure to cover the ground, despairingly adds that “in some instances the condition called hysterical can only be attributed to wickedness and perversity.” His attempts at a descriptive psychology of the malady consist of the remarks that “such patients talk a great deal of nonsense. They have an exaggerated feeling of self-importance ; seek attention from others ; and are as a rule never so pleased as when they become objects of attraction or sympathy, or are creating a sensation.”

simulation the conventional sentence that "one should not forget after all that hysteria is a disease," is often only too plainly an after-thought.

It is not maintained here that this lay attitude is either unfounded or unjustified—as we shall see, it contains in fact a germ of disguised truth—but there can be little doubt that it often serves to aggravate the sufferings of the patient. These are sometimes in themselves so bizarre as to provoke rather ridicule than sympathy, for instance in the case of a phobia of some familiar object or occurrence, and for this reason the patient is wont to conceal such symptoms from the persons of his environment. His failure to recognise the unconscious significance or logical meaning of his symptoms is accentuated by his friends' conviction that they have no meaning, except, possibly, an expression of his desire to irritate them, and this again adds in an indirect way to his distress. For nervous suffering differs strikingly from most bodily kinds in its inherent appearance of incomprehensibility: an absurd obsession haunts the patient's mind, a gust of fear or depression sweeps over him irresistibly and yet apparently without any adequate cause, and not the least of his terrors is the sense of an unknown but always present danger, of the impossibility of predicting the moment when some symptom, new or old, will suddenly take possession of his faculties. This feeling of being in the dark, of being able neither to understand nor to deal with the threatened peril, is often most distressing, and stands in contrast with the much greater feeling of security in regard to a physical disease, where usually one has at least some idea of what to expect, some guarantee of the

“reasonableness” of the ills—at all events not the utter uncertainty so characteristic of the neurosis.

Without pretending to exhaust the peculiar features of neurotic suffering, we have pointed out that there are respects in which it is more distressing than most forms of bodily ailment ; it is at least certain that a great many patients who have been subject to severe forms of both declare that the latter, however bad, is more endurable than the former.

2. Frequency of Neuroses.—Neuroses constitute perhaps the most widely spread form of disease. Persons quite unaffected in this way certainly comprise the minority of the general population. The high frequency-incidence of the neuroses is commonly underestimated through a number of considerations being incorrectly appreciated. A large proportion of cases never reach medical inspection at all. Many patients with obsessions, for instance, do not regard their condition as being strictly pathological and amenable to medical treatment, but struggle along as best they can, attributing their troubles to personal peculiarities. Others are too ashamed of the ridiculousness or of the unpleasant content of their obsessions to bring themselves to seek advice. Similar remarks apply to the numerous cases of sexual perversion and inversion (the latter condition alone is said to be present in two per cent. of the population), of anæsthesia and impotency, and of criminality of a neurotic origin. Then there should be borne in mind the tremendous frequency of drug habits and excessive drinking, the neurotic basis of which is now known. There is further the large number of people suffering from what may be called social

maladjustment, consisting in inadaptability, inefficiency, inhibition, incapacity to meet necessary situations, abnormally intense fear of death or of poverty, hopelessness or even despair, and so on ; it is now known that factors similar to those present in the neuroses are also in action in these cases. The appalling roll of yearly suicides—the least frequent outcome of such states of mind—should alone warn us against estimating too lightly these more social forms of neurosis.

Even of the cases that reach the physician a considerable proportion are not recognised to be neurotic, but are often wrongly diagnosed as organic disease, an error which, in spite of the prevailing opinion to the contrary, is commoner than the reverse. Some of these conditions we shall have occasion to speak of later ; instances are various vasomotor states (œdemas, etc.), many neuralgias, pseudo-angina and other cardiac syndromes, bronchial asthma, enuresis, pavor nocturnus, and particularly various gastric and intestinal conditions. It may be said in general that there is a tendency to attribute to local organic causes neuroses that have local manifestations : thus pollakiuria, spermatorrhœa, and dysuria to renal, prostatic or urethral disturbances, constipation to primary muscular atony, gastric symptoms to local toxins, visual ones to refractive errors, and so on.

Last, but not least, is the extent to which neurotic manifestations complicate and aggravate organic ones. When the diagnosis of a definite organic condition can be made, the tendency of the physician is very great to concentrate attention on this, to the neglect of any super-added neurotic one, and consequently to the considerable

detriment of the patient's welfare. Yet, quite apart from pronounced cases of neurosis, latent neurotic tendencies are so widespread that some or other manifestations of them are evoked by the physical disease in a large number, probably in the majority, of all illnesses, and may account for a considerable proportion of the actual suffering endured by the patient. It is safe to say, in conclusion, that of all the pains and ills which patients complain of, many more are due to neurosis than to any other single disorder.

3. Loss in Social Efficiency due to Neurosis.—

The loss in social efficiency resulting from neurosis is especially great, for the following reasons. Only a minority of the sufferers are totally incapacitated, so that those affected are mainly those engaged in carrying on the work of life, in public duties, earning activities, or the rearing of a family ; this of course means that much of this work is performed with less efficiency and success than would otherwise be the case. Further, the central symptom of any neurosis is the interference with social capabilities, this being of the very essence of the condition. With other diseases the family and persons of the immediate environment are affected by the incapacity of the patient, the sight of his sufferings, and so on, but with a neurosis there is more than this ; as we shall see later, one of the functions of a neurosis, one of its meanings, is the deliberate, though unconscious, provocation of distress in the persons nearest the patient, and this is indeed one of the reasons for that resentful criticism of which we spoke above.

It is highly important to realise that, strictly speaking, neuroses are not diseases in the medical sense at all, but only

in the social sense. In the former sense a disease is the product of interaction between an individual organism and an injurious, non-human environment, whether the latter be a physical trauma or an invasion of micro-organisms, endogenous or exogenous: on the other hand, a social disease is the product of interaction between an individual organism and a certain human environment. Put a little figuratively, it may be said that neuroses are the result of a conflict between the individual and society, whereas other diseases are the result of a conflict between man and nature. This fundamental distinction is often not grasped by members of the medical profession, who commonly regard all disease from the one standpoint; and the failure to grasp it is an important reason why the pathology of the neuroses has in the past been investigated so often with signal lack of success.

4. Relation of Neuroses to Psychoses.—Within the last dozen years it has been discovered that the study of the neuroses is not merely a useful, but an indispensable path to that of the psychoses. The common failure to appreciate the distinction between bodily and social diseases has been even more pronounced in the case of the psychoses than in that of the neuroses, and the early successes of morbid anatomy in elucidating the kinds of insanity due to the former type have unhappily served to accentuate this confusion. On the other hand, the knowledge gained through study of the neuroses has been applied with brilliant success to the elucidation of the previously unintelligible tangle of mental processes present in such conditions as dementia præcox and manic-depressive insanity, and it can now be affirmed positively

that no one who is devoid of this knowledge can hope to unravel the more complicated problems of insanity. The path to psychiatry from neurology and internal medicine necessarily leads through the study of the neuroses.

5. **Menace of Quackery.**—The neglect of the present subject by the medical profession has of recent years had serious consequences, the gravity of which shews little sign of diminishing. We refer to the increasing menace betokened by the prevalence of quackery, for there can be little doubt that the successes gained by quacks, which constitute the substantial basis of their prosperity, are for the most part gained in the sphere of the neuroses. The greater accessibility of their wares to the public that advances in modern advertising have made possible has furnished the opportunity for an attack on medical therapeutics at its most vulnerable point, namely, the treatment of the neuroses. Of similar incursions made by various movements under either the guise or the ægis of religion, such as Eddyism, Dowieism, theosophy, spiritism, Emmanuelism, etc., we shall have occasion to speak later. Fortunately, there has been of late a gradual realisation on the part of the medical profession that this state of affairs may in great measure be ascribed to their having failed to pay adequate attention to the psychological side of medicine in general, and that it is not due to the limits of medical therapeutics having been reached.

6. **Study of Neuroses and General Medicine.**—The last consideration that will be mentioned here, and not the least important, is that the study and treatment of the neuroses open a broader outlook for medicine than is possible with that of any other of its branches. The modern

psychopathologist is obliged to consider social problems, to study and form some estimate of social institutions, to an extent unthought of by the older generation of physicians. His attention can no longer remain confined to the narrower field of pathology proper, and on entering that of sociology he does so with ability to contribute special knowledge of the utmost importance. Collective psychology and sociology find their surest basis in a thorough acquaintance with the facts of individual psychology, and to no one are these facts so accessible as to the clinical psychologist. On such questions, for instance, as the education of children, both normal and abnormal, the status of marriage, which seems to be about to undergo considerable modifications, the significance of feminism and the relations of economics to sex, he brings new and fundamental points of view that will have to be taken into consideration by those who wish to form scientific judgements on these matters. As a critic of civilisation and its tendencies, of cultural movements and ambitions, his pronouncements will in the future have an authority perhaps second to none, instead of, as in the past, their being limited to the matter of physical health.

As particularly Freud and his school have shewn, the knowledge gained from the detailed investigation of the neuroses has already proved capable of throwing an astonishing amount of light on the psychology of both the normal and the abnormal. Contributions of the greatest interest have been made on the development of genius in one direction away from the average and of the criminal in the other, on character formation in the normal as well as in the eccentric, and on the significance of art,

religion, and philosophy. They have also revealed a remarkable closeness of structure between the imaginative phantasies of the individual, as manifested, for instance, in normal dreams or neurotic symptoms, and those of the people, as found in age-old myths, superstitions, folk-beliefs, and legends, and the interpretative study of the former class has furnished the key to the understanding of the deeper meaning of the latter. Not only mythology, but also such sciences as history, anthropology, and philology have also been extensively placed in the debt of the new science of clinical psychology, and the same is true of every branch of psychology. From all sides, therefore, the study, primarily with therapeutic aims, of the neuroses is building a science which transcends the narrower bounds of the older medicine, and is projecting this towards a dominant position in the highest sphere of knowledge, that of the mental and social sciences.

We have pointed out that from manifold aspects the study of the neuroses is of much greater importance than is commonly realised by members of the medical profession. It is not too much to say that at present there is no other branch of medicine so fraught with individual and social responsibilities, so promising in the lines of research it opens up, or so evidently destined to enhance the general importance of medical science.

DIVERGENT VIEWS

It is unfortunately true that in hardly any branch of medicine are there more divergent views expressed as on the subject of the neuroses ; this is so in regard to every aspect of it, ætiology, classification, pathology, diagnosis,

prognosis, and consequently also treatment. Such a state of affairs readily gives rise, in the minds of those who have not specially informed themselves on the matter, to the conclusion that, perhaps owing to inherent difficulties, there can be but little positive knowledge extant on the subject, and that the different opinions expressed by various writers represent merely so many ill-founded or as yet unproved speculations.

Now it cannot be too strongly stated that such a conclusion would be far from correct. Not only does a large body of definite and soundly based knowledge exist, but it can be shewn that the diversity of opinion prevailing on the subject is only in part, and even then only indirectly, to be traced to any inherent complexity in it. The truth is that the diversity is in much greater degree due to the circumstance that many of the opinions promulgated, even those issuing from men of authority in other branches of medicine, are to a remarkable extent of a superficial character, and are based on singular misapprehensions of the problems involved. A number of these opinions are indeed merely repetitions of the vague notions entertained on this subject before the advent of the new science of clinical psychology, and have about the same value at the present day as the guesses at the pathogenesis of various diseases that were current in the pre-bacteriological era of medicine. The reason for this curious state of affairs is that the present subject is concerned with (psychological) matters consideration of which is commonly approached by medical writers who are inadequately equipped for the task, who view the problems from the purely medical and physical aspects instead of from the

social and psychological ones, and who altogether fail to appreciate the important distinction between the two. In no other branch of medicine would it be possible for distinguished physicians to express judgements so out of harmony with the observable phenomena as commonly occurs in regard to psychopathological ones. The number of those whose training and research give a scientific value to their conclusions is, in comparison with the number of writers on the subject, deplorably small. From the mass of divergent opinions, therefore, a large number, certainly the greater part, have at once to be eliminated as being of quite subordinate value.

A simple instance of the current discordance of views is that concerning the prognosis and gravity of the neuroses. One may here roughly compare, with notable individual exceptions, the following series. The most favourable opinion given as to the prognosis of hysterical symptoms is as a rule that emanating from surgical specialists. According to laryngologists, for example, a case of hysterical aphonia is to be "cured" by an application of a faradic brush as readily as, according to ophthalmologists, one of hysterical blepharospasm or amblyopia is to be "cured" by other equally convenient procedures. One reason for this lightheartedness in the view of the case is evident. The next attack of aphonia commonly leads the patient to consult another laryngologist, to be "cured" afresh, and, in any event, it is only rarely that such specialists have any conception of what a small part of the whole clinical picture is constituted by the particular symptom for which their advice is being sought, or of the extreme readiness with which such symptoms

are replaced by others in regions not within their purview.

A general surgeon is usually more impressed by the obstinacy of the complaint, for he is more apt to be confronted with a history of several recurring symptoms, such as hysterical hip-disease, pseudo-appendicitis, self-mutilation, cutaneous gangrene, and so on. Both a special and a general surgeon, however, will often cheerfully undertake the responsibility for the care of such cases, with no apprehension of the complexity of the underlying morbid agents.

A neurologist, on the other hand, is likely to take a more serious view of the matter, partly because he sees more of the graver forms of the disease; and so is the general practitioner, who may be for many years perplexed by the tenacity of a given case that in the course of its evolution has presented a bewildering variety of manifestations. In both instances, however, the physician is apt to be influenced by the considerations adduced above, which, by impressing him with the apparent senselessness of the symptoms and the wilfulness, perversity, or even simulation of the patient, may lead him to withdraw his sympathy and understanding, with the result that he becomes to some extent blinded to the actual amount of suffering and inefficiency that the neurosis has imposed.

The psychopathologist, who has not only to give his attention to reviewing and investigating in detail all the present and past manifestations of the disorder, but also to estimating precisely the significance of them and their effect on the patient's life, becomes more and more chary, as his experience increases, about expressing too optimistic

an opinion on the future of a given case, and more and more rigorous as to his criteria of what constitutes a true cure. Many workers in this field consider hysteria to be almost as incurable as cancer, and limit their ambition to palliative efforts in the hope of at least making the patient's life fairly tolerable ; a man like Janet, for instance, with his almost unrivalled experience and with the special knowledge of therapeutics at his command, is dishearteningly pessimistic. A psychopathologist is often amazed at the glibness with which the word "cure" is used in connection with the neuroses, and is bound to contrast it with his experience of numerous cases that were at one time considered mild and thought to have been cured, but which later relapsed into the gravest forms of nervous invalidism. One sees cases of this sort that have been "cured" over and over again. In general it is a sound maxim never to be too confident in expressing an opinion as to the future of any case of neurosis, certainly unless it can be submitted to a much more radical treatment than is commonly employed.

The discordance just noted is a very simple one, being based on a mere matter of observation. If the estimate of the facts themselves differs so much according to the eye that views them, it is not to be wondered at that the more complex matter of interpreting the meaning of the facts differs still more greatly according to the mind that judges them. Further, the opinion as to the mode, duration, and thoroughness of treatment advisable in a given case must be expected to vary with the preliminary estimate made by the physician of the gravity of the disorder. Those who regard it lightly naturally treat it

lightly ; those who know its potentialities treat it more seriously. An amount of trouble and time that one physician might consider simply preposterous would be regarded by another as doubtfully adequate. Essentially this means that quite different tasks are being attempted by the different therapists ; whereas one is simply attempting to remove a given external manifestation of the disorder, and that for a time only, the other aims at effecting nothing less than a revolution in the patient's personality, at abolishing inhibitions, solving internal conflicts, healing and effacing old mental wounds, and freeing the patient from the encumbering weight of accumulated burdens so that he may be able to face with equanimity all that the future may have in store for him, and be truly equal to the battle of life whenever and however it may press.

From the point of view suggested here it is easy to understand why the methods of treatment presently to be described must differ above all in relative complexity, since the aims attempted are themselves different. It may be said with fair justice that the simpler the method the lowlier is the therapeutic aim, and that the more thorough it is the loftier is the aim. It is unfortunate that this is so, for the desideratum would be to find a simple method which could accomplish all that the more elaborate ones can do. As, however, this seems impossible, it is important to realise the true state of affairs. The more elaborate methods have been devised not from a perverse love of complexity, but from a dissatisfaction with the mediocre results yielded by the simpler ones.

In the following pages the attempt will be made to

lay stress on the aspects that the different methods have in common, rather than on those where they differ, and it will be seen that the diversity of them is due much more to a divergence of aim than to any heterogeneity of principle there may be involved.

CLASSIFICATION

It is necessary to come to a preliminary understanding on the matter of classification, for without it misconceptions are bound to arise. If, for instance, an author describes a method for the treatment of neurasthenia, it is imperative that we should know what he means by this term before we can judge of the value of the method ; it may well be a good one for the condition he has in mind under the term "neurasthenia," and quite unsuited for that which other writers understand by it. It would be out of place here to develop the principles of classification, and we shall confine ourselves to the task of presenting the matter as simply as is consistent with our aim—namely, of establishing a sufficient basis for comprehension of the different modes of treatment. It will further be necessary so to explain the division adopted as to allow the reader easily to find any syndrome which perhaps he may have been accustomed to see otherwise grouped.

The older classifications of the neuroses were, of course, purely clinical, based on observation of the course of the disease and concatenation of the symptoms. For more than half a century hysteria, neurasthenia, hypochondria, and the obsessional neurosis have been distinguished from one another, and these distinctions will be adopted here. Some thirty years ago confusion was introduced, in France,

into our conceptions of nosology through the exaggerated stress laid by Morel and others on the ætiological importance of mental degeneration. On the insecure basis of this hypothesis Charcot introduced the term "constitutional neurasthenia" and Janet the allied concept of "psychasthenia," and as a result of the prestige of these writers the idea has found wide acceptance. According to Janet, psychasthenia represents a unitary morbid state in the same sense as Kraepelin's dementia præcox does: that is to say, the common characteristics of the various syndromes included under this heading are more prominent than the differences between them, while each syndrome resembles the other members of the group more closely than those of any other (non-psychasthenic) one. According to the view here adopted, on the other hand, the premises on which this grouping are established are unsound, inasmuch as, through too much attention having been focussed on some features of the syndrome to the exclusion of others, the importance of the unitary bonds have been exaggerated and the distinctions between the individual syndromes not adequately appreciated. The cases described as belonging to this group would, according to the latter view, be regarded as really heterogeneous, the greater number being cases of mild dementia præcox (a disease unit which had not been recognised at the time when the conception of psychasthenia was being formulated), obsessional neurosis, anxiety-hysteria, and manic-depressive insanity (none of which conditions has even yet obtained general recognition in France).

Classification according to Pathogeny.—The first step to be made in the classification of the neuroses

is the recognition of the division between those in which the ætiological factors are predominantly physical and those in which they are predominantly mental ; the latter may be distinguished from the other neuroses by adding the prefix " psycho." It is not here maintained that the distinction between the two groups is in principle so sharp as some writers hold, but it is sharp enough to make the division one of considerable practical value, and it has the advantage of representing a distinction almost universally drawn. There are three simple or " actual " neuroses, neurasthenia, anxiety-neurosis, and hypochondria respectively, and four psychoneuroses, conversion-hysteria, anxiety-hysteria, fixation-hysteria, and the obsessional neurosis.

There are two other plain differences between the two groups besides the ætiological one just mentioned. (1) In the neuroses proper the pathogenic agents are operative at the actual time when the symptoms are being manifested (hence the term " actual-neuroses "), while in the psychoneuroses the more important ones always precede the symptoms—commonly by many years ; the ultimate causes of the former lie in adult life, of the latter in childhood. (2) The individual symptoms of a psychoneurosis are psychogenetically determined : that is to say, they can be shewn to have a definite meaning expressible only in mental terms ; on the other hand, no form of psychological analysis is capable of discovering any mental meaning in the individual symptoms of an " actual-neurosis."

It was remarked above that the distinction between these two classes of neurosis is, especially from a clinical point of view, not an absolutely sharp one, and increased

experience and study of them has tended to lay more and more stress on this fact. It has been found that a given amount of physical noxia will produce a much greater effect with one person than with another, and these individual differences can be traced to past psychogenetic factors of the type operative in the psychoneuroses. This evidently reduces the difference between the two classes, and almost makes it a matter of degree rather than of kind. In some cases the early psychogenetic factors are so important as to lead to an actual-neurosis being produced in the presence of physical noxiæ that normally can be tolerated without harm; in other cases these early factors, even if present at all, are of no greater importance than they are in the normal, and in themselves would exert no morbid influence, but the physical noxiæ are so potent (in amount or duration of action) as to lead to a neurosis; in still other cases both sets of morbid agents are operative, and it may be difficult to assign to each its relative importance.

The point just made is of considerable practical significance, for the following reason. The chief physical noxiæ are of such a kind as to be either easily remediable by a word of suitable advice or else to be almost impossible to remove; this will become plainer when we consider the individual examples under their appropriate headings. Now, in the latter event the therapeutic problem can be attacked from another angle. The psychogenetic factors can be dealt with, by methods later to be described, and it is remarkable how many patients can be relieved in this way; such patients, namely, can often tolerate without much ill effect the irremovable physical noxiæ alone,

whereas they are seriously affected if these are added to early psychical noxiæ.

Arrangement of the Book.—If the two main groups just indicated pass over one into the other, it is to be expected that the sub-groups will do so in an even greater degree, and this is found in fact to be the case. It hence comes about that a considerable number of generalisations can be framed which are equally valid with all forms of neurosis. The same applies to some extent to therapeutic measures, a circumstance that renders it inexpedient to try to cover the whole ground of therapeutics under each separate neurosis; indeed, to do so would involve an intolerable and quite impracticable amount of repetition. What will be attempted, therefore, will be to discuss the line of treatment appropriate to each neurosis, and to indicate the section under which is to be found the more detailed account of the measures suggested. For reasons explained in the preface, the subject of mental treatment (psychotherapy) in general is described under the heading of hysteria.

It need hardly be said that in a work of this kind the subjects of pathology and diagnosis can be dealt with only in the briefest way, and what may be said on them will be strictly subordinated to the main purpose of the book. Some reference to them, however, is quite unavoidable, for without at least a partial exposition of the different views held the accounts of the various therapeutic procedures would be largely unintelligible; I shall thus try to avoid a common error committed in so many books on psychotherapeutics, particularly those on suggestion, where the subject of treatment is apt to be described quite

empirically, instead of being based on a consistent pathology. It is also evident that we shall be concerned with the principles of treatment rather than the details of application, for some of these, such as hydrotherapy, the use of electricity, etc., are in no way peculiar to the treatment of the neuroses, while others, particularly some of the psychological procedures, would necessitate a much more extensive exposition than would here be possible ; it is hoped, however, that even with the more elaborate of these latter methods sufficient practical indication will be given to enable the physician to undertake some application of them as well as to enter on a more thorough study of the subject.

CHAPTER II

HYSTERIA

THE term is here used in accordance with current usage, so that no discussion of the symptomatology or nosological status of hysteria will be necessary ; Babinski's distinction of hysteria of various vaso-motor and other syndromes from hysteria is not here accepted. The views as to its pathology and treatment may conveniently be divided into two classes, according as they lay stress on the physical or the mental aspects.

A. PHYSIOLOGICAL MEASURES

In the middle of the last century, and even later, at a time when the conception of disease as essentially a problem in morbid anatomy reigned unchallenged, attention was especially attracted to the physical manifestations of hysteria, these promising best to afford a clue for the discovery of the seat of the supposed lesions. A paralysis or tremor of the arm was regarded as indicating an under-action or over-action respectively of the cortical arm centre, though it might just as well have been attributed to an affection of the brachial plexus so far as the actual characteristics of the symptoms were taken into consideration. The microscope obstinately refusing to disclose any changes in such centres, the convenient conclusion was

reached that the fault lay in the imperfections of the microscope rather than in the reasoning, and that these changes were too minute to betray themselves except by disturbances in function. A relic of this fiction is to be found in the now antiquated expression "functional nervous disorder," which is still used in many medical and even in some neurological text-books.

It need hardly be remarked that this simple view of hysteria has been quite discredited by the researches of the last thirty years, and the only reason why the method of treatment based on it calls for any discussion here is that it remains the orthodox one and the one most frequently recommended ; as a matter of fact, it is still useful in some circumstances, though it produces its beneficial results in a very different way from that which was originally intended.

The classical example of the physiological type of therapeutic measures is the well-known *Weir Mitchell treatment*. This has had a rather curious history. Of the four elements comprising the treatment, namely, over-feeding, massage (with or without electricity), isolation, and rest in bed, the last two are the most familiar at the present day, but for Mitchell the nutritional element was the cardinal one, as he indicated by the title of his book (*Fat and Blood, and How to Make Them*), and all the others were of quite subordinate importance to this. Starting from the two gross assumptions, first that the disturbance in hysteria consists in an irregular and unstable functioning of certain brain cells, and secondly, that this irregularity must be due to insufficient nutrition of these cells, the attempt was made to remedy the disorder

by deliberately overfeeding and fattening the patient. Mitchell himself deprecated confining the patient to bed, but was ultimately led to include this in his treatment, partly because he found it was easier to fatten resting patients than ambulatory ones, and partly on grounds of expediency, as a means of dealing with the numerous patients who came to consult him from a distance. He regarded it as nothing more than an unfortunate necessity, however, and was careful to limit the duration of the rest in bed to six weeks ; it is thus a little irony of history that his treatment has come to be known as "the rest cure." The massage and electricity were also originally merely secondary adjuncts to the chief aim, being necessary corollaries of the overfeeding and rest.

The feature that has proved of most significance in the treatment, apart from the personality of the physician, is that of isolation. In many cases this exerts a distinctly favourable influence, its good effect—evidently a purely mental one—being due to the respite from various pathogenic social factors. In many other cases the effect of isolation is the very reverse of beneficial, and may even be calamitous ; one reason for this, but by no means the only one, is the increased opportunity for fruitless introspection and hypochondriacal worrying, combined with the withdrawal from social activities and interests that had furnished at least a partial outlet for the disharmonious tendencies.

The personality of the physician, and his mental handling of the case, is a still more important factor in the treatment. It is now known that the satisfactory results that have sometimes been obtained by the Weir Mitchell

treatment have been chiefly brought about by the suggestive influence of the physician, a matter which will be discussed later, and this is the great reason why the treatment has yielded such strikingly different results in the hands of different men. With a remarkable personality, such as that of Mitchell himself, it is not at all surprising that it has been possible to achieve good results in certain cases, but the variation in its effect, and the frequency of disappointing failures, have demonstrated that we have not here a method such as was originally hoped for, namely, a series of purely physiological measures on which definite reliance could be placed.

Three things may be postulated about the Weir Mitchell treatment with a considerable degree of certainty : first, that every one of the individual component measures in it may at times be used to advantage, particularly when they are combined with more radical methods of treatment ; secondly, that the main effect of the treatment is a mental one, being identical with that produced by other modes of suggestion ; and thirdly, that each measure in it—from the electricity to the personality of the physician—may affect patients very differently according to their mental individuality. The last point may be illustrated by the example of overfeeding by means of large quantities of milk. It can be shown that the different reactions displayed by patients towards milk, the avidity with which some take it, the extreme aversion that others have towards it, depend on the way in which the idea of the substance has been previously associated in the patient's mind. In patients of the second type the idea is intimately associated with various buried thoughts that to them are

extremely unpleasant or even nauseously disgusting, and their reaction towards the harmless substance itself is determined by these unconscious associations and feelings. If this connection is made plain to them by means of a suitable mental analysis, so that they realise how they have been reacting, not towards the idea of milk alone, but towards other ideas with which this was unconsciously associated and which become stimulated by its presence, then their physical aversion to the substance may entirely disappear, as I have seen happen in a number of cases. This example illustrates the general proposition that the individual influence of the Weir Mitchell treatment is much more complex than at first sight appears, and is impossible to predict beforehand without knowing a good deal about the patient's personality.

If for any reason it is desired to employ the treatment, then this should be done, not as a blind, unintelligent application of a mechanical procedure, as is too commonly the case, but in combination with some form of mental investigation that will enable one to gauge and check the precise effect that the individual measures are having on the patient's mind. With this indispensable proviso it may be said that each of them may at times be employed with considerable benefit, although there is not one of them that is ever really necessary. Without this proviso, however, appreciable harm may be done, such as the inducing of increased agitation, hypochondria, or despair, as I have seen in a number of cases.

Improving the patient's nutrition commonly heightens the patient's sense of well-being and self-confidence, thus helping him to face his difficulties. Even overfeeding

may be justifiable in certain cases, particularly with thin, irritable patients, and can do good by tending to produce a general placidity. Electricity, of however potent or sensational a variety, has little action except on the mind, and for this purpose is quite superfluous. Massage may be useful, not only for bettering the general nutrition, inducing calm and sleep, but also for improving the blood-supply in limbs with vasomotor disturbances.

The question as to when *isolation* is desirable is often a most delicate one to decide. Lévy and others have with right protested against the indiscriminate employment of it still in vogue, while, on the other hand, with some systems of treatment, *e.g.* Déjerine's, it plays a central part. Cases undoubtedly occur where the domestic environment militates so powerfully against the efforts towards recovery that it is very advantageous to remove the patient from it, at least for a time, but it must never be forgotten that the therapeutic aim should be, not to meliorate the environment and thus ease the patient's difficulties, so much as to train him to face them with equanimity, or at least to tolerate them without an abnormal amount of distress. In the more analytic methods of treatment this consideration is especially important, for the actual difficulties and frictions that arise from day to day in the patient's ordinary life afford most valuable material for the study and elucidation of his general tendencies, and the truth of any given conclusion can often be put to an almost experimental proof in a way that would be impossible with an artificial environment. At all events there can be little question that isolation is much too readily and automatically

resorted to ; it is a path of least resistance, but it produces the least satisfactory results. One often sees patients, it is true, who have been temporarily benefitted by isolation, but if nothing else has been done to alter their mental condition they naturally tend to relapse as soon as they return to the environment with which they were previously unable to cope. Illusory hopes are thus aroused in the minds of both the patient and the physician, to be dashed when they are put to the test of actual experience. A good rule to follow is that every effort should be made to get the patient to enter into some suitable form of activity, whether work, hobby, study, or other interest, as early as possible in the treatment, and the physician should regard isolation, though sometimes unavoidable, as always an unfortunate interference with the ideal plan ; it should be reserved for the last resort, much as a hypnotic drug is for the relief of sleeplessness.

We must therefore relegate the Weir Mitchell measures to the position of useful adjuncts, and cannot regard them as serious attempts to deal with the morbid condition itself.* The same is evidently true of all other physiological means of treatment, most of which are admittedly only symptomatic. Hysterical retention of urine may sometimes make catheterisation necessary, and insomnia may call for hydrotherapy. There are cases of anorexia nervosa, with actual danger to life from starvation,

* It is a striking illustration of the prevailing ignorance of medical psychology that some physicians even to-day teach their students that the Weir Mitchell treatment is a "specific cure" for hysteria—a poor way of preparing them for the difficulties they will surely meet with in practice.

in which forcible feeding may, at least for a time, be indispensable, but such a measure is of course no more a cure for hysteria than it is for conscientious objection. Constipation, diarrhœa, flatulence, and vomiting are not infrequently manifestations of hysteria, and in some cases temporary benefit may be derived from the exhibition of the medicinal measures ordinarily employed for such symptoms ; the same remark applies to the manifold pains, headaches, neuralgias, coughs, heterophorias, polyurias, and a host of other symptoms. But in all these cases recourse to physical remedies, though occasionally an unfortunate necessity, should always be regarded as in a sense a confession of failure, for all these symptoms can really be satisfactorily dealt with only by discovering and then adequately dealing with their mental significance. Physical treatment of an hysterical symptom, and *à fortiori* of hysteria itself, is similar to the treatment of retention due to urethral stricture by means of puncture of the bladder. This analogy, indeed, is applicable in more respects than one, for not only is it in the two cases a question of affording temporary relief while the main pathological condition is left untouched, but the element of urgency enters into both ; an hysterical symptom that, by allowing one no time to remedy the underlying mental factors concerned, obliges one to adopt alleviating physical measures, is a symptom of which the treatment has been neglected until the occurrence of a preventable emergency.

A matter of considerable importance may be mentioned in the present connection—and that is that many hysterics have an unusually strong tendency to develop drug habits;

the praiseworthy reluctance on the part of most physicians to employ hypnotics, cocaine, and particularly morphine, with such patients is therefore thoroughly justified.

The remarks made above on the subject of isolation apply, with but little modification, to that of *change of scene*, including holidays and travel. This often, though by no means always, procures a similar alleviation of the symptoms, but it accomplishes nothing in the direction of getting the patient to deal better with the difficulties at the root of his malady. To recommend a voyage abroad is practically a confession on the physician's part that he is unable to treat the case and renounces every attempt to do so ; it is a blank failure on his part, and would be regarded as such in any other field of medicine. One cannot avoid the suspicion, indeed, that at least with some physicians such advice is merely an expression of their desire to remove to a distance cases that arouse in them nothing but a baffling sense of impotency.

The various so-called "*work cures*" do not deserve such strong condemnation, though here too the main problems are largely shirked. The beneficial element such systems of treatment contain is best discussed, however, in another connection, and we shall return to it later.

B. GENERAL MANAGEMENT OF HYSTERICAL CASES

Whatever line of treatment may be decided on in regard to a given case, there are certain general principles, of wide validity, which it is always desirable to bear in mind. These will be discussed under two main headings.

I. "*Inadequate*" *Emotional Reaction*

It is necessary to remember that the apparently unreasonable reactions, behaviour, and attitudes of hysterics are never meaningless, as they so often seem to be, but when properly investigated always prove to be well grounded and fully intelligible. It is a matter of common observation that such patients react differently from the normal, sometimes towards only a few types of situation, sometimes towards many. The example of fear may be taken: an hysteric may be afraid of objects, situations, or occurrences that excite no fear in the normal; he may, on the other hand, be strikingly unafraid of things that normally excite anxiety; and in the case of those that normally excite a certain amount of fear the hysteric may experience either more fear than is to be expected or else less. This sort of behaviour, perhaps more than anything else, is the reason for the description—one might almost say the accusation—of want of balance, disturbance of mental equilibrium, and instability which is so often applied to them; the instability seems especially appropriate in the cases where the patient reacts to the same situation now in one way, now in another. The healthy person feels such patients to be abnormal; he cannot predict how they are going to react and behave, and he cannot understand them; this sense of non-understanding is of precisely the same nature and origin as that experienced in regard to the insane, differing only in degree. Things seem to have a different significance for the hysteric from that which they have for the normal; there is present a "transvaluation of their values."

It is not the least of the triumphs of modern clinical psychology to have shewn that this shifting of values, leading to what is technically called "inadequate reactions,"* is more apparent than real. The observation that a given patient may be more disturbed by a certain occurrence than a normal person would be is perfectly correct ; the common inference from the observation, however, that such a reaction is excessive or exaggerated is erroneous. In both quantity and quality it is exactly the same as that of the normal, strange as this statement may appear ; the difference between the two is that the reaction of the hysteric is to a greater extent than that of the normal "over-determined" by the process known as "displacement." These terms call for a word of explanation, which may best be given by means of a simple illustration from daily life. A young child who has once been hurt by a doctor, *e.g.* during the dressing of an abscess, may for some time after be fearful of any other doctor, however innocent the latter's intentions. The child has "displaced" his affect † of dread from the one doctor to the other, or one might say : all doctors have become "identified" together in his mind, much as if they constituted a unitary person ; his attitude towards this imaginary composite is partly determined by his unhappy experience, and he behaves towards the second doctor just as though he were the first. Overcome by his strong affect, the child is unable to distinguish between the two men in feeling,

* This expression was unfortunately chosen, for the word "inadequate" usually implies a deficiency, whereas the reaction referred to more often concerns an excess. "Disproportionate" would be a much apter term.

† *i.e.* feeling.

however well his reason may be able to effect this distinction for him ; all he can think of is the important resemblance between them. His attitude on the second occasion, when meeting the previously unknown doctor, may appear to a stranger to be one of exaggerated and unreasonable cowardice ; when correlated with the earlier experience, however, it is at once felt to be quite human and thoroughly intelligible. Now, the case of the hysteric is precisely similar. All his so-called exaggerated and abnormal reactions are due to the circumstance that the situation he is reacting to is intimately connected in his mind with another one, in the case of which his reaction was perfectly natural and explicable. Properly speaking, he is reacting, not to the present situation, but to the old one, or at best to the combination of the two, and however abnormal his behaviour in regard to the present one may appear, it is seen to be quite intelligible and "adequate" as soon as this is realised and his attitude correlated with the significance of the earlier situation.

As was indicated by the example quoted above, the occurrence of displacement, the being influenced in a present situation by the memory of a similar previous one, is a perfectly normal process. The most prominent distinctions in this respect between an hysteric and a healthy person are (1) that the former is more extensively influenced by past memories than is the latter, and (2)—a necessary accompaniment of this—that the associative connection between the primary and secondary situations is not so evident. The first of these distinctions concerns a fundamental part of the theory of hysteria, as we shall later have occasion to remark.

At present we may confine our attention to the fact that the hysteric is *to an abnormal extent* influenced by his past, and may be said to be still living largely in his past; the reason for this we shall discuss later. It is simply another way of putting the familiar generalisation that the hysteric is imperfectly adapted to the reality of the present.

The second distinction just mentioned may conveniently be illustrated by returning to our example from normal childhood. The resemblance here between the primary and secondary situations, the two medical visits, is so evident as to be appreciated as soon as it is mentioned. Now, in certain cases the child's dread may be so intense as to be evoked by a much slighter resemblance, for instance, by the sight of an approaching stranger who is carrying a black bag or wearing a silk hat. It is plain that here the casual observer might quite fail to realise what was going on in the child's mind, and would be more prone to judge his behaviour as unreasonable than in the earlier instance we gave. To an average adult the resemblance between a commercial traveller and a doctor is a relatively faint one, and the common feature that they may both carry black bags is so trivial as to be readily obscured by more important differences; to a child obsessed by a dread of doctors, however, no resemblance is too trivial to awaken the thought of possible danger. The same matter might be illustrated by many other examples from daily life, from the domains of love, of hate, of anger, and so on, but it should not be necessary to do this. The essential point is that even in the normal the presence of intense emotion has the effect of compelling

attention to the resemblances between any given idea on the one hand and the idea inherently accompanying the emotion on the other, and of obscuring the differences, however obvious these may be, that exist between the two ; this law is of cardinal import in psychology. Thus a woman terrified of railway accidents thinks of danger at every little jerk of the train, a man apprehensive of bankruptcy is panic-stricken by an insignificant fall in stocks, a soldier fearful of treason suspects a spy in every stranger who behaves a little unusually, and so on. The calm and objective onlooker may not notice the resemblances between these sets of ideas ; the connection between the jerk of a stopping train and a railway accident is to him too far-fetched to enter his mind, and the sight of a man with a camera does not evoke such a distant idea as that of danger to his country. In technical language the process just described is expressed by referring to the remarkable assimilative capacity of a complex ; * when the affect of a complex is unusually intense, ideas that resemble, however distantly, those of the complex are assimilated to its sphere of activity—on the basis of associations which to the objective observer seem totally inadequate. The extent to which the associative activity of the complex radiates is directly proportional to the intensity of the emotion investing the complex. It follows from this that the more superficial are the associations between two ideas

* A " complex " denotes a group of connected ideas, invested with a strong body of emotion and having a definite conative tendency (wish, longing, etc.). In actual practice it is found that such localised groups of ideas always present some propensity towards dissociation, the extent of which varies considerably in different instances ; consequently there is generally some portion of the complex that is repressed in the unconscious.

that have in this way been drawn together, the stronger must be the emotion responsible for the establishment of the connection. Hence one must be prepared to find that with the most important complexes, *e.g.* those of pathogenic significance, the resemblance between what we have called above the primary and secondary situations is often an exceedingly forced one, one which would readily be overlooked by an observer not possessing the specific interest that emotionally binds the two.

To unravel the train of mental processes in hysteria that leads the patient to react to so many situations of the actual moment as though they were the repetition of more important past ones is often a matter of very considerable difficulty, not only because, as has just been mentioned, the connections between them are commonly so strained as not to occur spontaneously to the observer, but also because these are usually unconscious, *i.e.* not known to the patient, and he exhibits a strong and instinctive disinclination to recognising the presence of them.

Practical Corollaries.—Some corollaries of considerable practical importance follow from the appreciation of the matters just discussed. The chief one is that in dealing with hysterical patients one should estimate their "abnormal" reactions and conduct *empirically*. Knowing that though concretely false they are psychologically true, and that therefore from the patient's point of view they are quite justifiable, one has to take them at their face value. For instance, when a patient is morbidly terrified at such a situation as being in a closed space, this is not something unreasonable, false, and in a way unreal, as is commonly assumed by a judgement based only on

consideration of the external reality ; it is, on the contrary, a fact of import, deserving of serious consideration as such. The patient has very good reason to be afraid of something, though this something is not what it appears to be, the idea of a closed space ; not only, therefore, is the fear itself a real one, but it has a real and quite intelligible cause, though one which can be appreciated only by first elucidating it. The strangeness of the process resides in the displacement of the fear from this cause on to an idea that otherwise would have been more or less indifferent, and which remains indifferent for the normal person ; some attribute of the idea of a closed space is also an attribute of the causative idea of which the patient has every right to be afraid, and he experiences fear in the presence of anything which tends to remind him—whether directly or indirectly, consciously or unconsciously—of this.

In dealing with these abnormal reactions the physician may attempt violently to overcome them, by ridiculing them, ignoring them, and so on. If his suggestive influence over the patient is sufficiently great he will sometimes succeed in this, at least for the time being, but if he systematically ignores the truth that many matters have an obviously different significance in the patient's mind from that in his own, that they mean more to the patient than they do to him, he will surely sooner or later—in all but the mildest cases—evoke the patient's antipathy or hostility, who will then leave him with the complaint that " he does not understand him " or that his " personality is unsympathetic " to him. This attitude of regularly underestimating the significance of the patient's individual reactions, likes and dislikes, attractions and antipathies, though in many

cases it undoubtedly produces certain effects—for good or ill—is not designed either to achieve a comprehension of the deep-lying morbid agents or to control and guide these so as to lead to a more harmonious functioning. By these remarks it is not at all meant that the physician would be doing right in yielding and pandering to all the foibles and whims of the hysterical patient—on the contrary, he should be constantly labouring to approximate the patient's attitude in such matters to that of the normal—but that the abnormal reactions should be regarded seriously as having a definite meaning and reason, that proper weight should be attached to them in giving the patient this or that advice, and that every effort should be made to understand them.

It is further a matter of common observation that the attitude of such patients towards the physician, as towards all other people with whom they come into close contact, is apt to be changeable, fickle, difficult to predict, and, generally speaking, unreasonable. Little things in the physician's conduct may be responded to in an excessive manner: a change in his tone of voice, some personal trick or mannerism, the use of certain words about which the patient has an idiosyncrasy, a feature in his personal appearance, any such thing may serve to produce a remarkable change in the patient's attitude towards him, may cause respect to be replaced by antipathy, irritation, apprehension, hate, or—most disturbing of all—affection. It is this fickle behaviour of hysterical patients that often leads physicians to regard the treatment of them as an ungrateful task, one to be avoided whenever possible. And yet, as will have been surmised from the preceding

remarks, the matter is far from being so meaningless as it appears. We have here merely another example of the hysterical "displacement," of the living in the past and reacting to it over again in the presence of current situations that in some way, however slight, resemble it. What has happened on these occasions is that the patient has, usually unconsciously, been reminded by the physician of some person of significance in his past life, and that he has transferred to him various emotions which concerned the previous person, and which have not been absorbed in the normal way with the passage of time. He is thus reacting not toward the physician, but rather toward the other person who has been brought together ("identified") with the latter in his mind, an occurrence technically known as "transference." This tendency of the hysteric to link together the people of earlier years, particularly those who have played a prominent part in his affective life, with the people he now has to meet differs from the corresponding normal one in the respects of which we have previously spoken. It is only one form of his general tendency to view to an abnormal extent all his present life in the light of the past. An hysteric is always out-of-date in his emotional reactions.

From this point of view one also apprehends better the meaning of the conclusion, frequently propounded, that the hysteric fails to deal adequately with current reality, that he is mal-adjusted to his actual environment. The main reason for this has been indicated above; namely, the patient is too much influenced by his past, and hence cannot appreciate at their intrinsic value the situations of the present, estimating them rather by the value

attaching to earlier ones with which they have become associated in his mind.

It is plain that a physician who carefully studies a patient's reactions, and correlates them with a detailed investigation of the influences of his past life, will be able not only to understand much better the changing attitudes referred to above, but also to detect much earlier the slight manifestations of the processes underlying them than one who goes his way regardless of such matters, expecting the patient to behave normally, and being helplessly surprised when he does not ; it is the difference between working in a good light and working in the dark. There is no single feature of any form of treatment of hysteria more important than the regulating of the personal relation between the patient and physician ; failure here not only signifies complete defeat of the therapeutic endeavours, but may mean something even more serious—namely, that the patient, through the physician's fault, is left in a worse state than before. It need hardly be said, therefore, that too close thought cannot be devoted to this matter, one which is often neglected in the most careless way. Tact and nice perception will, it is true, do much to prevent such failure, but they are often inadequate unless supported both by a suitable knowledge of the ways in which the relation may be affected and by as full an investigation as possible of the individual patient's past life.

2. Resistance

One of the most striking differences between hysteria—indeed, between all the psychoneuroses—and any

form of organic disease is that in the former there is always some mental force in the patient striving against his getting well. This is a rule with absolutely no exception, however much the patient may protest to the contrary. He may have any number of quite genuine motives for wanting to get well, and so far as he is aware he may be thoroughly desirous of getting well, but there is invariably some force acting in the opposite direction ; to it is given the name of " resistance " (*i.e.* to the therapeutic efforts of the physician).

Once this idea is appreciated a number of commonplace observations become more intelligible. To begin with, we have the familiar type of patient whose objection to getting better seems to be expressed almost openly. He constantly has important engagements that prevent him from keeping those with the physician, or he forgets about them and arrives late ; he omits to carry out the latter's prescriptions and brings forward all sorts of excuses for this, the most characteristic being that he has " forgotten ; " he pays no attention to the advice given, except perhaps by way of pursuing the opposite ; he puts obstacles in the way of all the therapeutic aims and thwarts them with the utmost ingenuity, until at last the physician in despair feels tempted to ask him point blank, " Do you or do you not want to get better ? " This is the stubborn or refractory patient, whose illness seems to be a question of sheer perverseness.

Then there is the patient whose symptoms are so suspiciously well-timed. With this type the attacks of convulsive seizures, painful neuralgias and headaches, general trembling, or what not, occur only under obser-

vation, and stay away for long periods when the patient is left to himself. Often the symptoms seem to be deliberately directed against a given person, and occur only in relation to him, altogether revolving about his movements and conduct. I have seen a patient remain perfectly well so long as her husband was at home, developing a complicated train of disabling symptoms when he went away, so that he often had to be sent for ; he was a commercial traveller, and one of the motives of the patient's illness was the desire that he should change his work and thus be able to lead a more continuous domestic life. As contrast to this I can call to mind many patients who were well only when their husbands were away from home, and where one of the functions of the illness was to induce suffering and sympathy in a too neglectful husband. In some cases the symptoms have the appearance of a metaphorical sword held above the family's head ; attacks make their appearance as soon as the patient is denied something or disappointed, and cease as if by magic the moment his request is granted. Many such patients completely tyrannise over the whole household ; their lightest whim has to be obeyed, and their likes and dislikes attended to, on penalty of an outburst of suffering, due of course to the unkindness or cruelty of the recalcitrant relative. This is the calculating patient, whose illness seems to be produced by pure wilfulness.

Very similar to the last is the patient whose symptoms form a close copy of some one else's ; it may be some one they have heard of, seen, or read about in the newspaper. This is the imitative patient, whose illness seems to be a matter of simulation. It is in connection

with this type that so much is said about the hyper-suggestibility of hysterics, the important point being commonly overlooked that the copying of symptoms is never indiscriminate, but usually betrays a considerable degree of selection. The study of the particular symptoms copied by a given patient leads one much farther towards a knowledge of the real nature of hysteria than does the satisfaction, displayed by such writers as Babinski, with the use of the word "hyper-suggestibility."

Lastly may be mentioned the type of patient who actually does manufacture symptoms. Well-known instances are the various cutaneous lesions, from vesication to gangrene, the hæmoptysis where the blood originates in the gums, the glycosuria where the sugar comes from the larder, the deliberate or only half-accidental mutilations and accidents, and so on. This is the deceptive patient, whose illness seems to be a deliberate malingering.

None of these four attributes, of perverseness, wilfulness, simulation, and malingering, represents a justifiable conclusion, except as the grossest possible approximation to the truth ; the kernel of truth that is contained therein will be indicated later. Nevertheless the feature common to the types in question is that of a manifest resistance to the idea of health, or—presented in its obverse form—a Will to Disease. Some writers, indeed, such as Kohnstamm,* go so far as to formulate the rather crude generalisation that a "defective health conscience" is the specific characteristic of hysteria.

If the same matter is considered from another point of view it becomes plain that in many cases of hysteria

* *Allg. Zeitschr. f. Psychiatrie*, Bd. lxxviii. s. 522.

the patient achieves a certain undeniable gain from being ill (Freud's so-called *Krankheitsgewinn*), which he would have to renounce in the event of recovery. This gain is by no means evident in all cases, but in most cases of long standing it becomes fairly manifest. The illness is used as an excuse to avoid all sorts of disagreeable duties and tasks, both household and social, various little allowances are made for the patient and favours granted that a healthy person could not expect, and life in general is artificially softened so as to make his sufferings more tolerable.

It must be definitely pointed out that the patient, for quite precise reasons, is much less aware of the advantages and gains brought by his illness than might at first sight be imagined. This sounds strange, for they are often obvious enough to the observer, and it can only be accounted for by supposing that the patient shirks the realisation of them. As we shall see later, there are good grounds for believing this to be the case ; it well explains, among other things, the resentment displayed by the patient when the state of affairs is pointed out to him, and also the obvious reluctance with which he renounces his previous advantages on getting better. If the patient is only partially aware of the gains that accrue from his illness, he is still less aware of the fact that they serve as *motives* to maintain it. And yet that this is often the case stands beyond all reasonable doubt ; the conclusion is based on countless observations that admit of no other interpretation, and with the so-called *Rentenhysterie* that followed on the German disablement acts it was demonstrated almost statistically. In fact, one does not go far wrong in always inquiring as to the effects produced by an hysterical

illness and then regarding quite empirically these effects as causes that have at least an adjuvant influence in maintaining it ; whoever investigates this point of view for the first time will be astonished to find how fruitful it is.

If one notes carefully the reaction of an hysterical patient when it is suggested to him that the gains brought about by his illness are motives in maintaining it, one not only sees that he indignantly repudiates the idea, but also becomes convinced that he is not necessarily dishonest in doing so. The knowledge of the truth may perhaps be in his mind, but it cannot be said that he is aware of it ; he does not wish to be. There are certainly cases in which the patient is aware of it, but these constitute the minority ; the following is an instance. A lady with severe hysterical symptoms was sent to me for treatment. After a month or two, when she was already a little better in spite of the obstacles she put in the way, she very honestly said to me one day : “ You are wasting your time and labour, doctor, for I can see plainly that I don’t really want to get better ; getting better would mean going back to live with my husband, and all that that brings with it.” Her husband was a drunkard, who was repellent to her mentally, morally, and physically. I may add, however, that continued treatment gradually diminished her excessive repulsion to an extent that made life quite bearable.

From this point of view we can understand one of the grounds of the patients’ resistance to therapeutic efforts, and also why they are so loath to acknowledge its existence. Getting better signifies not only the renouncement of a number of previously enjoyed advantages—never a proceeding very cordially entered upon by any human

being—but also making the disagreeable admission to one's self that the illness had been exploited for the sake of these advantages : at least, no form of treatment that does not involve this admission can afford any guarantee that the same factors will not automatically come into action again as soon as a suitable opportunity presents itself. A good physician is therefore necessarily a disturber of the peace, and as such is either openly or veiledly opposed.

The chief therapeutic corollary that follows from these considerations is that the physician, if he conscientiously desires to deal with the actual causes of the malady—in other words, if he desires to make his treatment radical and not merely palliative—must constantly be on the alert to discover the motives that have produced and are maintaining the condition. By attaining in this way to a clearer appreciation of the patient's relation to his environment he is better able not only to understand his reactions to it and to base the details of his advice on a sounder comprehension of their significance to him, but also in many cases to effect adjustments in the environment of a kind accurately adapted to the individual needs of the case. His knowledge of the patient's resistances, and of their importance, will make him realise the necessity for the utmost tact wherever they may be concerned, but will make him none the less determined thoroughly to overcome them, or rather to help the patient to overcome them. This is the inner meaning of the hackneyed expression "kind but firm," which is so often reiterated but so rarely heeded. The physician will also attach the greatest value to the motives opposed to these resistances, for the

sake of which the patient desires to get better, and will cultivate them by every possible means, in a way that is hardly necessary in the case of most organic diseases. These latter motives constitute his essential support in all the difficulties of the treatment, and without them no serious benefit can result from any therapeutic effort.

A few words may be interpolated here on the importance of the preceding reflections for the *theory of hysteria*, since the observations on which they are based, and which can readily be verified in everyday practice, must be taken into account in any attempt to formulate such a theory. We note in this connection a striking difference between the two views of hysteria that will be discussed later, and which may be termed the *shock hypothesis* and the *wish hypothesis* respectively. It is hard to reconcile the observations in question with the former of these, which would trace hysterical symptoms to the effect of various psychical traumata in past life—griefs, frights, accidents, war experiences, etc. ; the two matters do not seem to connect well together, and the hypothesis affords no adequate explanation of the phenomena. With the “wish hypothesis,” on the contrary, they are in the fullest harmony. According to this view *all* hysterical symptoms result from various personal wishes, they represent a peculiar mode of gratifying these, and they all bring a certain gain to the patient. In the examples chosen above this is easily to be perceived, for the symptoms serve to get the patient what he wants, *i.e.* to gratify his personal wishes ; but the “wish hypothesis” goes much further than these surface observations, and maintains that careful investigation reveals behind every single symptom a desire

acting as a motive, a desire that in some way is being gratified by the existence of the symptom. We have noted above two characteristics of the wishes that are gratified by the patient's exploiting his illness, first that he is only imperfectly or even not at all aware of them, and secondly that he is very reluctant to acknowledge them when they are pointed out to him. These characteristics are much more prominent in the case of the deeper and less obvious motives ; here the patient is absolutely ignorant of their existence, *i.e.* they are "unconscious," and he displays a strong instinctive resistance to any procedure that threatens to unveil them.

Three forms of mental therapeutics will be described later. Of these the "wish" and "shock hypothesis" correspond with the first two respectively, though only to an imperfect extent ; the third one incorporates both hypotheses in a whole.

Summary.—A short summary may now be given of the chief points developed in the present section. Attention has been called to what is termed the "inadequate emotional reaction" characteristic of hysterical patients, to the frequency with which they react to a given situation in a manner or with an intensity different from that of the normal ; situations, ideas, objects, persons, commonly possess an unusual and apparently unintelligible significance peculiar to the individual patient. This transvaluation of their values has been traced to the undue extent to which they are influenced by past situations that in some way resemble the actual one of the moment, the patient's reaction being partly towards the former (primary) one and partly towards the latter (secondary)

one. It was further pointed out that the stronger the emotion attaching to the primary situation the less obvious need be the resemblance connecting any secondary one with it for the memory to influence the latter, the association between the two being often a forced or superficial one. Put in other words, it may be said that this "displacement" of emotion from a past situation to a present one is a manifestation of the assimilative capacity of a strong "complex." Characteristic of hysterics, especially as distinguished from the normal, is the excessive extent to which they are influenced by past experiences, so that in severe cases they really seem to be still living in the past. We have remarked on the practical importance of the physician's realising that the patient's inadequate reactions are only apparently such, being incongruous only when the present situation alone is taken into consideration; they are in fact perfectly justified in both quality and quantity, and are quite intelligible when correlated with the past situations by which they are determined. Abnormal reactions have therefore to be regarded, not as exaggerated or false, but empirically as psychologically true, though displaced as regards time and occasion.

In the next place, attention has been directed to the fact that various advantages accrue to the patient from his symptoms, and that these advantages often serve as motives in maintaining the malady; the effects of the latter may thus in many cases be regarded as causes. The patient is commonly unaware of the action of these motives, and resents any measure calculated to force them on his notice. It was further hinted that many more symptoms

are due to unconscious motives, and serve to gratify unconscious wishes, than might at first sight appear. In every case of hysteria there exist, by the side of the manifest reasons for which the patient desires to get better, important counter-forces opposed to these, and therefore tending to thwart any therapeutic endeavour ; they are usually unconscious. Two of these forces were commented on, one being the patient's disinclination to renounce the gains resulting from his illness, the other being his aversion from acknowledging the way in which he has exploited his illness for egocentric purposes. This Will to Disease, when opposed to the therapeutic efforts of the physician, is termed " resistance," and to learn to understand and deal with the various resistances is one of his most delicate and yet most important tasks.

The essential outcome of the preceding discussion is the conclusion that success in the treatment of hysteria is closely to be correlated with the amount of trouble taken in investigating the past emotional experiences of the individual patient, this being indispensable for both the understanding and control of the morbid tendencies. Merely to prescribe some form of rest, in the pious hope that the pathogenic agents will thereupon cease their activity, and that the patient will get better if only he is left alone and fed sufficiently, is as inadequate a therapeutic proceeding as it would be to do the same in a case of obscure abdominal disease with no investigation of the ætiological factors ; in both instances many cases may actually recover if treated in this way, but in neither has the physician done his best for the patient, or given him the benefit of modern medical science.

C. PSYCHOLOGICAL MEASURES

I. INTRODUCTION

There is undeniably a considerable body of prejudice still obtaining among the medical profession against any kind of mental therapeutics, and this in spite of the propagandism in the opposite direction during the past quarter of a century. It arises from several sources, of which the following are probably the most important.

It is evidently a matter of profound regret to some physicians that no adequate physical measures have been discovered to effect the same results as mental ones in the treatment of hysteria, and they use all their influence to dissuade others from what they are pleased to call "contamination with the unclean thing." This curious attitude arises in part from a bewilderment on a purely philosophical topic, the relation of body to mind, the complete irrelevance of this for the subject of practice not being realised. Accustomed to regard all disease as essentially an affair of the body, and adopting a grossly materialistic attitude towards the mind, they feel any attempt to influence it from the mental side to be a disturbing intrusion on a scheme of things that has hitherto given them a feeling of security and familiarity. Actually the study and practice of mental therapeutics in no way involve one in any form of philosophy, good or bad; a psychotherapist may be a monist, a dualist, an adherent of any philosophical school or of none at all, and there are instances of each of these types among those most prominent in this work at the present day. The theory

of mental therapeutics is based on two incontrovertible and everyday observations : first that occurrences of the kind called mental, such as grief, fear, and so on, are often followed by injurious occurrences of the kind called bodily disorder ; and secondly that these disorders can be beneficially affected by other mental states, such as happiness, hope, and so on, which can be induced by certain mental measures designed for the purpose. Any one adopting such a procedure may believe that all these mental states, both the pathogenic and the curative, are accompanied by physical changes in the brain, or even that they are grossly produced by these in much the same way as bile is produced by changes in the liver ; but such beliefs, or the absence of them, have no necessary relation whatever to the empiric procedure of healing the patient. One may or may not hold similar beliefs in regard to the normal, for instance, in connection with the matter of teaching a boy how to solve algebraical problems, but neither our uncertainty on the point nor our obvious inability to instil such training by means of specific drugs, diet, or other physical measures, has weighed heavily on our educators, or prevented them from adopting other means that achieve the desired result.

Another source of prejudice is the evident truth that the early history of mental therapeutics is closely interwoven with that of non-medical healing in general, and of charlatanry in particular. When the practice of medicine was gradually emancipating itself from the hands of the priesthood, the process was not thorough-going enough to include mental therapeutics (then applied in the form of faith-healing, exorcism, and so on), and what part of

this is not still retained by the somewhat intermittent efforts of the clergy has become the heritage of quacks to a greater extent than of physicians. Even now to many medical men the very idea of mental therapeutics has a distinct flavour of the non-rational, or actually mystical, and is not absolutely separated in their minds from that of imposture ; they tend to regard a cure induced in this way as a sort of cheat, a jesuitical achievement of a laudable aim by ignoble means. The modern study of psychopathology, on the other hand, has especially set itself the task of restoring the subject of mental therapeutics to its original position as a branch of medical knowledge, and of founding the practice of it on a scientific basis. Although this task has been seriously attempted only in the past few years, mental therapeutics itself is of extreme antiquity. It reaches back beyond the dawn of history, and is probably as old as the earliest form of religion. This is as true of civilised as of savage nations, for the Father of Medicine, Æsculapius, whose ophitic emblem is still our own, was above all a psychotherapist. This honourable descent, when now quickened by the touch of modern science, should augur an important and worthy future.

The strongest and most deeply rooted prejudice of the medical profession against mental therapeutics is in my opinion the prepossession against any measure that appears to give one human being an undue influence or control over another, with the increased responsibility that this brings. This is particularly strong in the case of one that seems to interfere with the very personality and free-will of another, even more so than the feeling,

with which it may be compared, about intruding on individual privacy that for a long while retarded the development of gynæcology. It is no doubt connected with very fundamental attributes of mankind concerning the liberty of the individual and still deeper emotions; emotional and irrational factors such as these affect conscious judgment to a greater extent than is sometimes recognised. It is well known that this attitude was especially pronounced in regard to treatment by means of hypnotism or suggestion, and it is probable that the greater part of medical prejudice against mental therapeutics in general is a radiation from the opposition to this most familiar form of it. It is indeed quite common for the terms "psychotherapy" and "hypnotism" to be regarded as synonymous, or even identical, and many books bearing the former title treat only of the latter subject. Sir William Osler, in his text-book of Medicine, writes: "To treat hysteria as a physical disorder is radically wrong. It is essentially a mental and emotional anomaly, and the important element in the treatment is moral control." It is instructive, as illustrating the current medical attitude on the subject, to find that, even after making this clear pronouncement, he actually mentions no form of mental therapeutics except hypnotism, and this only to warn against the use of it.

In reality, there is a great variety of psychotherapeutic modes of treatment. As it would be impracticable, as well as unnecessary, to describe all the countless modifications here, an attempt will be made to classify them into a few main groups, and in this way to indicate the principles underlying the different forms. It would seem possible,

by means of a unitary criterion, to graduate the various forms in a fairly even ascending scale ; the criterion in question, which for the sake of brevity may be referred to as the " activity criterion," is *the extent to which the patient himself is made actively to bring about changes in his mental functioning*. Doubtless an endeavour in this direction is made in all forms of mental therapeutics, but it is certainly more pronounced in some than in others. The reason why this particular criterion is chosen as the basis for classification will presently become more evident. One important one is that the main progress effected in the whole subject during the past quarter of a century consists in the gradually increasing stress that has been laid on the principle indicated. Originally the chief therapeutic factor relied upon was what may broadly be called the personal relation subsisting between the physician and patient, commonly referred to as the " personal influence " of the physician ; although this factor can from the nature of things never be altogether eliminated, progress in mental therapeutics as a science has largely consisted in replacing it, so far as possible, by the " activity " factor mentioned above, and in one form of treatment, the psycho-analytic, a serious endeavour is made to reduce the after-effects of the personal factor to a minimum.

The three main groups that comprise our classification are those of suggestion, re-education, and psycho-analysis respectively, and they will be considered in this order. Some cavilling may be expected concerning the sub-groups that will be introduced under the main ones, it being perhaps thought that some of them deserve a more prominent and independent status, but I can only say

that I am aware of the objections that may be raised, and that I have substantial reasons in favour of the course here adopted.

II. SUGGESTION

Suggestion is not only of peculiar antiquity, being probably the oldest form of any kind of therapeutics, but it is perhaps the most widely used one at the present day, entering as it does to a greater or less extent into every medical relation with a patient. One often reads that every doctor uses suggestion, consciously or unconsciously, and from this truism the curious inference is sometimes drawn that the medical profession has nothing new to learn in the field of mental therapeutics; this reasoning, which is evidently founded on an identification of suggestion with mental therapeutics in general, is almost as quaint as if in 1890 it had been said that, since small-pox had long been known to be contagious, the medical profession had nothing to learn from the new science of bacteriology.

Hypnotism.—We may appropriately begin with the subject of hypnotism, the most striking form of treatment by suggestion, the one in which the personal influence of the physician plays the greatest part, and the one where the medical investigation of psychotherapy was inaugurated. The term "hypnotism," coined in 1843 by Braid, who probably contributed more to our general knowledge of the subject than any other single man, has long since displaced those of "animal magnetism" and "mesmerism," of which it was the lineal descendant.

Numerous abortive attempts have shown that it is

extraordinarily difficult to define precisely in what the actual state of hypnosis consists, and this for two reasons : in the first place, the individual manifestations occur with the greatest irregularity, so that there is no constant group that one can seize as essential, while in the second place there is an imperceptible gradation between the deepest stage of hypnosis and normal waking life. These and other circumstances have led some observers, notably Babinski, to deny the objective reality of hypnosis altogether as a distinct mental state, though this is a conclusion in which few acquainted with the facts will acquiesce.

It is undoubtedly in many cases a difficult question to tell whether a given person is hypnotised or not, and at what moment this can truly be said of him. When, however, a number of the most characteristic manifestations are present it is easy to say that the person is in a different state from his normal one: when, for instance, he can recall forgotten memories in a way quite impossible in his usual waking state, when his limbs are in a condition of catalepsy and his sensibility to cutaneous stimuli abolished, and when he reacts to external suggestions in a manner quite foreign to his normal behaviour; as a rule, this deep "somnambulic" stage is followed by amnesia for all that has occurred during the *séance*, and brings with it the capacity to develop the process known as post-hypnotic suggestion. It is not necessary here to detail the phenomena of hypnosis, but attention must be directed to the following matters that have a special therapeutic bearing: (1) To the heightened suggestibility, which is perhaps the best-known feature of the

condition. (2) To the widening of the memory field that frequently occurs. (3) To the circumstance that verbal suggestions can produce not only mental effects, and not only effects on bodily processes that are under control of the will (limb movements, etc.), but also effects on bodily processes that are entirely out of control of deliberate volition; for instance, changes in various secretions, renal, mammary, salivary, and lachrymal, in the peristaltic activity of the intestines, in various cutaneous and vasomotor processes, and even in the menstrual function. (4) To the peculiar *rapport* that exists between the physician and patient. This is present to some extent in all cases, being probably the most constant feature of any. When it is at its acme, so intense is the preoccupation of the patient with the thought of the physician that he is in contact with the outer world only through him; he quite ignores any stimulus, even a painful one, emanating from any other source.

Method.—The methods employed for the induction of hypnosis are very numerous, but there are certain features common to them all. In the past various physical agents and apparatus, from Mesmer's *baquet* to Luy's revolving mirror, were employed, and even at the present day some operators make their patients listen to the sound of a metronome or stare at some bright object. It is, however, well established that none of these measures is necessary, and it is doubtful if they are ever of much assistance, except perhaps to give greater confidence to the physician. Certain preliminary conditions are desirable, and often essential. The patient's previous mental attitude is important. Every effort should be made to

give him confidence, and if possible belief, to induce in him a state of mental calm, and to allay any fear or apprehension that may be present. For these reasons it is desirable to give beforehand some simple description and explanation of the procedure, but this should be short, not too complicated, and given in a quiet reassuring tone. Anything that tends to induce a peaceful frame of mind is a useful adjunct ; for instance, a room free from any disturbing noise, absence of bright light, complete bodily comfort. Many authorities resort to sensory stimulation, the features aimed at being those producing monotony and fatigue : the former may be compassed by rhythmic stroking of the skin, of either the hand or brow, or by setting a metronome going ; sensory fatigue may be brought about by getting the patient to fix his gaze for some time on any object, preferably a bright one, which is best placed above the level of horizontal vision. All of these, however, are only accessory measures. The essential procedure consists in leading the patient to relax, both physically and mentally. This is usually done by means of direct suggestion on the physician's part, whether in the form of a command, a hint, or a prediction. The patient should renounce activity of thought, and avoid the slightest sense of effort, such as the pursuing of a given train of thoughts ; this is sometimes aided by his concentrating on a simple idea, but it must be an easy, lazy concentration, not an active one. His attitude should become that of a peaceful passivity, an abstraction, a total relaxation of all strain ; he enters into a state of *dolce far niente*. With refractory or incredulous subjects there are a number of special devices that may be

employed. A simple one, first recommended by Levy-Suhl, is the making use of the physiological process of colour-contrast : a strip of bright grey paper is pasted on to a piece of bright green or blue glass which has a white background ; the operator's prophecy that the strip will presently become coloured, from without inwards, will surely be fulfilled in a few seconds, except of course with certain colour-blind subjects.

When the patient has attained the desired stage the physician proceeds to exhibit the specific suggestions relating to the symptoms. This may be done in the form of a peremptory command, of a gentle persuasion, a personal appeal, and so on, varying according to the type of patient and the custom of the physician. The suggestion may be directed immediately against the particular symptoms, or the matter may be approached quite indirectly ; this also should vary, according to the critical tendencies of the patient and the kind of symptom. In all cases it is desirable to repeat the suggestions many times over, preferably in different words. The essence of the whole treatment is that the force of suggestion is directed against that producing the symptom ; the important question of the nature of these forces will be discussed later.

Therapeutic Results.—The therapeutic results of hypnotic suggestion are undoubtedly in many cases very gratifying to the patient and his relatives, and there is no question that the potency of it has been considerably underestimated by those members of the profession who are either not familiar with the facts or unskilled in the use of the method. It succeeds much better with hysteria

than with any other neurotic condition. To see a patient with an hysterical paralysis of years' standing enabled to use the limb after a single hypnotic treatment is an experience that is difficult to parallel elsewhere within the bounds of medicine, and one which makes the descriptions of such places as Lourdes quite intelligible. This sensational brilliancy, however, constitutes only one aspect of hypnotism, and there are others by no means so satisfactory. As is well known, a series of objections have been urged against the method, and for these and other reasons it has not been generally accepted by the medical profession, the percentage of whom that make use of it being extremely small in all countries. Many of the objections raised can be shewn to be not justified when the evidence is properly investigated; nevertheless the prejudice existing against the method does not all arise from mere meaningless conservatism, as has sometimes been maintained—it may be remembered that it has vainly struggled for medical recognition for well over a hundred years—but is more solidly founded than many of the superficial pretexts urged by those sharing it might lead one to suppose. However, it will be well to postpone discussion of the subject until it can be taken up together with that of suggestion in general, of which it is only a part.

It is necessary to call attention to the fact that the induction of hypnosis may serve other therapeutic purposes than that concerning the administration of verbal suggestion, and this applies equally to the sub-varieties of hypnosis. In the first place, it can be said that the mere induction of the state is of itself in some cases of

considerable therapeutic value. Not only may the patient's general sense of well-being be thereby heightened, though as a rule this effect is a transitory one, but also various symptoms may automatically disappear. Sometimes, no doubt, this is due to definite suggestions unconsciously given, or expectations aroused, by the physician, but there is good reason to believe that improvement may occur quite independently of these ; insomnia is a striking example of this. In the second place, hypnosis may be induced purely for the purpose of exploring forgotten memories that are inaccessible in the waking state, and which it may be desirable for the patient to recall ; the importance of this will be discussed in connection with the re-education methods.

It was mentioned above that the state of hypnosis differs only in degree from the waking state, and that a series of obscurely marked-off stages can be distinguished in this gradation. To divide these stages into a definite number is quite artificial and conventional, as indeed is shewn by the circumstance that very few authors agree on the same division ; thus Delboeuf, Gurney, and Dessoir mention two stages, different in each case, Forel and Charcot give three, also different one from the other, Liébault six, and Bernheim nine. Such divisions may be convenient for the purpose of illustrating a given point, but they are obviously of no general validity. All of these stages or sub-varieties of hypnosis also occur spontaneously in hysteria, and perhaps in other maladies as well.

One example of these sub-varieties may be used to illustrate points that apply equally to other members of

the main group. In 1893 Breuer and Freud * gave the name of "hypnoid states" to certain important manifestations of hysteria, calling attention at the same time to the resemblance between them and the lighter grades of hypnosis. Binswanger † compared them with the sub-variety termed *Hypotaxie* by Forel (1891); the comparison is equally evident between them and the sub-hypnotic states called *cataplexie* (Preyer, 1878), *état de fascination* (Brémaud, 1884), *léthargie lucide* (De la Tourette, 1889), and particularly with the *état de charme* described by many of the older magnetists. Several of these varieties have been represented as constituting specific mental states, with particular therapeutic possibilities, and have been exploited as such. A few years ago Sidis ‡ described, apparently independently, a method for inducing the hypnoid condition, giving it the name of "hypnoidization." It is defined as consisting in the production of a "state of abstraction, of mental composure and relaxation," *i.e.* the features mentioned above as indispensable in every form of hypnosis; the details used in the method of induction are also familiar to every hypnotist. Like the other writers, Sidis assigns a high theoretic significance to the "hypnoidal state" (*i.e.* a hypnoid condition produced not by hysteria, as described by Breuer and Freud, but artificially, as described by the other authors), and also asserts that it possesses a special therapeutic potency. It should not be necessary to have to refute these exaggerated contentions, although they seem to

* Breuer und Freud, "Studien über Hysterie," 1895, S. 9.

† Binswanger, "Die Hysterie," 1904, S. 316.

‡ Sidis, "The Psychology of Suggestion," 1898, p. 224, and "Psychopathological Researches," 1902.

have misled some physicians unfamiliar with the wider aspects of the subject. It is sufficient to remark that none of these hypnotic sub-varieties has any pretension to specificity, that no feature distinguishing one variety from another is of any general importance, and that none of them possesses any quality of either theoretic or therapeutic bearing that may not be found both in typical hypnosis and in the waking state.

Suggestion in the Waking State.—We pass now to the subject of suggestion in the waking state, a mode of treatment more widely accepted and much more commonly employed than hypnotic suggestion. Not long after the scientific investigation of the phenomena of hypnosis was undertaken it was discovered that in suitable cases, particularly with hysterical subjects, they could all be produced in the waking state, and what was of more practical importance, that the same therapeutic results could be achieved with patients in this state. So far as therapeutic suggestion is concerned, it would seem to be irrelevant, or at all events unimportant, whether the sleep-like manifestations characteristic of hypnosis are present or not. It is known that most, if not all, of these are due to the conventional suggestions in this direction that are given when inducing the condition. Dessoir pointed out, for instance, that the closing of the eyes in hypnosis is usually due to this, and that if suggestions referring to the eyes are avoided, the deepest hypnosis may be induced with the patient's eyes open throughout; I have repeatedly found this myself, as no doubt other observers have. The circumstance that so many of the phenomena thought to be characteristic of hypnosis are not inherent in the hypnotic state, but are

purely the products of verbal suggestion, renders it even harder to distinguish between hypnotic suggestion and other kinds.

In employing simple suggestion in the waking state, all that is necessary is to ensure that the patient is in a condition of repose and mental calm, that he has replaced the normal mental activity of pursuing and attending to various trains of thought by a state of abstraction, and then to utter appropriate suggestions concerning the symptoms in just the same way as in the case of hypnotism. The chief practical difference is that the physician omits the preliminary suggestions designed to induce a state of hypnosis. In both cases it is essential that he should impress the patient as having a complete confidence in himself and an unquestionable belief in the efficacy of the statements he makes.

Comparison of the therapeutic results obtained by waking and hypnotic suggestion is not easy, a remark which holds good of any two forms of mental therapeutics. *A priori* one might imagine that, since heightened suggestibility is such a prominent characteristic of the hypnotic state, the susceptibility of the patient to therapeutic suggestion must be greater here, and the benefit received more marked. Comparative experience, however, does not seem to bear this out, or at least certainly not to the extent that might have been anticipated; the explanation of this probably lies in the consideration mentioned above—namely, that the accessory, sleep-like manifestations that characterise hypnosis are non-essential. The majority of those accustomed to use both methods do not consider that hypnotic suggestion presents any noticeable

advantages in this respect over that given in the waking state, and my own experience is in full accord with this conclusion. The workers who placed the whole treatment by suggestion on a firm basis—namely, the Nancy school, with Liébault and Bernheim at their head—have for many years consistently maintained this conclusion. Forel, a strong advocate of hypnotism, goes so far as to hold that there is absolutely no difference, from either a theoretical or a practical point of view, between hypnotism and waking suggestion. It is further significant that a number of authorities who formerly employed hypnotism, such as Milne Bramwell, Van Renterghem, and others, have practically renounced this in favour of simple suggestion, that is to say, they proceed to give therapeutic suggestions at the beginning of the *séance* without waiting for any effect of suggestions designed to induce hypnosis, or even without giving any of the latter kind of suggestions. From the numerous successes published the conclusion may be drawn with certainty that the hypnotic state is at all events far from being indispensable to the obtaining of therapeutic results.

Suggestion in the Sleeping State.—Finally, mention may be made of another way of administering suggestion, namely, during sleep. Several workers, Wetterstrand in particular, have shewn that it is often possible to enter into a mental *rapprochement* with a sleeping patient, and thus to lead him directly from the state of sleep into that of hypnosis, no intermediary waking stage being necessary. Once the *rapprochement* has been established, it is possible to administer suggestions without inducing a state of hypnosis proper. Therapeutic suggestion during sleep

has been most often used in cases where the patient is obdurate against any form of treatment, for instance, with alcoholics ; the results obtained in this way have been mediocre, and the obvious practical inexpediency of the method need not be pointed out. It has also been used in the case of semi-responsible patients who refuse to consult a doctor, but care must be taken here not to overstep the bounds set by medical ethics ; I have never myself seen a case of this kind where I could convince myself that the treatment was justifiable. On the other hand, the method has a distinct field with children who are too timid to be suitable for ordinary suggestion, and I have had beneficial effects from it in such cases.

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Up to the present we have considered only the methods in which suggestion avowedly plays the most prominent part, and where the giving of therapeutic suggestions is the chief aim of the treatment. It has long been recognised, however, and recent investigations have fully confirmed the conclusion, that even when this is not the case, and even when such suggestions are to some extent refrained from, suggestion in the sense of the personal influence of the physician plays an extremely important part. In some forms of treatment the effects reached in other ways are of so little consequence in comparison with this influence that it is appropriate to consider them in the present section.

Persuasion.—A typical example of these forms of

treatment is that by means of what is called persuasion. Babinski attempts to divide verbal suggestions into those that are unreasonable and potentially harmful and those that are reasonable and beneficial. He reserves the term "suggestion" for the former and "persuasion" for the latter; the condition in which symptoms can be evoked and removed by means of suggestion he calls "pithiatism." There is plainly no psychological difference between the two processes, for it is obviously a matter of convention or of external and irrelevant circumstances whether a given suggestion is to be considered reasonable or not.* Nevertheless, in the attempt to introduce a more "rational" procedure we see the germ of a new principle differing from those underlying the simple treatment by suggestion described above. This resides essentially in greater emphasis being laid on the matter of stimulating the patient to take an active share in modifying his mental state, his reaction to the treatment being less of an automatic response to the physician's efforts than in the case of pure suggestion. In other words, there is here the beginning of the aim that was chosen above as the criterion on which to base the classification of psychotherapeutic methods. The physician tries to "appeal to the patient's reason," and to enlist on his side the mental process known as reasoning.

This form of treatment has been especially developed and expounded by Dubois, and, through his indefatigable advocacy of it and his personal success in the use of it,

* This matter is fully discussed by Mohr, "Die Beziehungen zwischen 'Überredung' und 'Suggestion,'" *Journ. f. Psychol. u. Neurol.*, Bd. XIV., S. 202, to which the reader may be referred.

the term "rational psychotherapy" has become closely associated with his name. The belief on which treatment by persuasion is based is that the patient himself has the power to modify beneficially his pathogenic mental processes, provided he has the help of a physician to explain what is needed and to direct his endeavours. It will be shewn later that this principle is of the highest importance, but it by no means follows that every system of treatment that involves it is capable of applying it ; and this failure is particularly evident in the case of the persuasion treatment.

The application of the principle clearly presupposes both a knowledge of what the pathogenic processes that have to be altered really consist in, and also some understanding of the circumstances of their origin and the conditions of their pathogenicity ; without such knowledge and understanding one would only be working in the dark. Now the persuasion treatment, as described by all its advocates, is very far indeed from satisfying this presupposition. The symptom in question is taken at its face value, as though it were the pathogenic process itself, and any inquiry that may be made into the pathological significance and origin of it is altogether inadequate. Indeed, in many cases the "explanation" given to the patient merely consists of a series of truisms, or even banal platitudes, such as when a patient afflicted with a morbid fear of open spaces (agoraphobia) is told that open spaces are safe to cross and that there is really no need for him to be afraid. It is quite comprehensible that a physician who takes such a superficial view of the problem should come, as Dubois has come, to regard neurotic

symptoms as manifestations of a pitiful intellectual weakness and lack of logical reasoning capacity, a conclusion which is absolutely contradicted by any unprejudiced observation of such patients.

The defects of the persuasion treatment are mainly two. In the first place, an exaggerated value is attached to the therapeutic potentialities of reasoning processes, to the neglect of the more important affective ones. Déjerine, a later worker than Dubois in the field of persuasion, has recognised this, and has attempted, not very successfully, to combine the rational element of the treatment with attention to the affective factors present. The problem is essentially not an intellectual or logical one, but an emotional one, and there is a definite limit to what can be accomplished by reason and cold logic alone. This over-estimation of the intellect is due to the simplistic view that neurotic manifestations proceed from ignorance, want of thought, or lack of native intelligence, and that the patient would not suffer from them if only he knew better. The aim of the treatment thus reduces itself to the correction of errors of thought by conveying to the patient various pieces of information. In the second place, it is assumed that the aberrant mental processes that have to be corrected are conscious ones, a fundamental misapprehension, for, though of course the actual symptoms are conscious phenomena, they are only the surface manifestations of deeper psychopathological processes of which the patient is entirely unaware. Without any knowledge at all of the nature of these primary disturbances one is naturally powerless to affect them one way or the other, and all that can be done by means of

surface methods is sometimes to shift and vary the external manifestations.

There can be little doubt that whenever any beneficial result is achieved by the use of "persuasion" the main part of it is due to the suggestive influence of the physician, so that the method may be regarded as a sub-variety of the group now under consideration. The appearance of the method and the interest aroused by it, however, are facts of general significance as indicating a dissatisfaction with what is felt to be the unreasoning blindness of treatment by suggestion, and a desire to found mental therapeutics on a more rational basis. Though this laudable tendency has proved unfruitful in the hands of those who have confined themselves to the simpler persuasion methods, it will be seen later that it has given an impetus to more serious studies concerning the nature of the problems involved, with the result that forms of treatment have been devised dealing more radically with the pathogenic processes.

Education of Will-Power.—Another method, developed especially by Lévy, may be mentioned, which includes elements taken from both of the preceding ones. In it an attempt is made to explain to the patient that his symptoms are unnecessary, being based on faulty habits of thought and diminished self-control, and that if he were to exercise more "will-power" he could overcome them. There is thus a distinct flavour of moral disapprobation in the physician's attitude, just as there so commonly is in that of the patient's relatives. The theory underlying the method, however, is not devoid of a certain kernel of truth. The symptoms are, in fact, produced by the patient's will, and can also be abolished by the action

of this, if under the word "will" is understood the sum of desires and strivings that go to make up the mind, both conscious and unconscious. The defects of the method are that it ignores the nature of the unconscious pathogenetic "will" (or rather tendencies), and so fails to make it accessible to the action of the conscious "will"; further, it attempts to suppress the symptoms altogether without diverting into more beneficial directions the energy that creates and maintains them. The more painstaking the preliminary investigation, the more can be accomplished by this method of treatment; but in practice it often degenerates into a mere preaching and moralising, the effect of which depends upon the success of the accompanying suggestive influence.

"Side-tracking."—Lastly, a method may be referred to that differs more widely from that of pure suggestion than do any of the preceding ones; to it the name "side-tracking" has been applied. It has been developed and elaborated most fully by Putnam, with his assistants Taylor and Waterman. The principal aim of the method is to divert the patient's attention so far as possible away from his symptoms, and to stimulate his interest in healthy activities. It thus forms an extension of the so-called "work-cure," a more intelligent study being made, however, of the mental potentialities of each individual patient than is usually the case in the "work-cure." Many institutions, such as the Social Service department of the Massachusetts General Hospital in Boston, and those forming part of the recent Mental Hygiene movement in America, also do much to provide external opportunities for the development of such activities.

Like the preceding methods, this one is very far from being radical ; but in certain cases where the spontaneous efforts towards recovery are sufficiently strong, satisfactory results may be obtained. In point of fact, it follows on precisely the same lines as these spontaneous efforts. When recovery takes place in hysteria apart from treatment, it is always through the forces that had been making for illness having become diverted into other, healthy paths. It should specially be noted that this statement is more accurate than the customary one to the effect that these forces become *replaced* by other tendencies of a more normal kind. The pathogenic force is diverted, not replaced ; it is the same force that is operative, in the case now of the symptoms, now of the healthy activities. The principle of this mode of treatment is thus perfectly sound ; the imperfection of it is that with so many patients the tendency of the pathogenic forces to act in the old way is fixed by certain factors with which the treatment does not deal. In other words, for the patient to be able to take advantage of the treatment the pathogenic agents must possess a certain degree of flux, a proviso that applies to only a relatively small number of cases, and these of the milder variety only. It is only in these circumstances that the method gives at all satisfactory results, though as a supplement to more radical modes of treatment it has considerable value. Putnam himself has felt this, and now practises * one of the more elaborate methods—that known as psycho-analysis—using the “ side-tracking ” method as

* This unhappily should be in the past tense, for since these lines were written Dr. Putnam has died, to the deep regret of all who knew him.

an accessory according to the needs of the case. The method has been included in the present group on the grounds that the critical element of getting the patient to modify the pathogenic agents themselves is not at all prominent, and that the beneficial effect is largely produced through the natural tendency to recovery being aided by the encouragement and personal influence of the physician.

GENERAL CRITICISM OF THE SUGGESTION TREATMENT

A given method must be judged both by the empiric results it achieves and by its compatibility with the principles of treatment indicated by our knowledge of the disease. Of the two the former criterion is evidently the more important, and, if the excellence of the results surpasses what consideration of these principles would lead us to expect, the latter are probably imperfect. This, however, cannot be said about the results of the treatment of hysteria by suggestion. As was mentioned above, the immediate results are sometimes exceedingly brilliant, and it is only natural that these should be vaunted by enthusiastic advocates of hypnotism, whether lay or medical. In many cases, moreover, the beneficial effect of the treatment is a permanent one. Nevertheless, it is unquestionably true that a considerable proportion of cases where it was thought that a complete cure had been achieved relapse later, and may need repeated courses of treatment. This plainly would not be a decisive objection to the method were there no better ones available, but as there are the objection has to be seriously weighed, for the unsatisfactoriness of any treatment by suggestion is that the possibility of relapse is a defect inherent in the method,

and one that can never be excluded. This is true of any form of treatment in which the actual morbid agent is left untouched, a criticism that strikingly applies to the method in question. The principle laid down in our discussion of the general management of hysteria, namely, the cardinal importance of properly investigating the details of the patient's inner mental life in so far as they bear on the genesis of his malady, is here absolutely contravened. Apart from the unfortunate possible consequences of this that were pointed out before in the previous connection, the result is that the physician is quite in the dark as to what is actually going on in the patient's mind at the time. He can never be sure whether or no any given case will prove to be one of the fortunate ones that remain cured ; he can hope that it will, but he cannot afford the slightest guarantee on the point. Even if all his therapeutic endeavours are successful, and the case appears to be cured, he can know absolutely nothing about the various buried and latent tendencies to the production of symptoms that have never yet occurred, but which may, and often do, as soon as the manifest symptoms have been removed. From the nature of things he can deal only with those symptoms that are in evidence, or have been so in the past ; he cannot foretell what kind of symptom is likely to be produced by the neurosis in the future, and therefore can do nothing to anticipate or prevent it. If, finally, there are alternative methods of treatment that explore and deal with the actual pathogenetic agents, that treat the disease and not merely the existent symptoms, and that can prevent both the recurrence of the old symptoms and the fresh production of new ones, then

obviously they must be regarded as more satisfactory than treatment by suggestion.

On the other side it must be said that many of the objections that have been urged against the present group of methods, most strongly against hypnotism, are based on very insufficient grounds. It is often said, for instance, that the treatment sometimes lasts unduly long and consumes an unreasonable amount of time ; it may in very rare cases even take a hundred *séances* before hypnosis can be induced. Individual judgment in this matter will naturally vary according to the view held as to the severity and importance of hysterical suffering, also as to the prognosis of such cases and the ease or difficulty of relieving them. There are cases that any one might well be proud to have cured within five years, and there are still others that have to be regarded as incurable even in this time.

It is further said that such measures open the possibility for influence of a wrong kind being exerted on the patient. This consideration is perhaps an argument in favour of the prevention by the State of the use of mental therapeutics in general except in the hands of medical practitioners, but it is no more applicable in the case of the medical profession than similar apprehensions of misuse in regard to chloroform, potent drugs, scalpels, and other constituents of the therapeutic armamentarium. The charge that repeated *séances* of suggestion are apt to produce in the patient an unfortunate dependence on the physician has more truth in it than the other ones brought forward, and were there no other methods of treatment that are free from this disadvantage it might be a nice question whether it outweighed the good done or not.

If we turn to the theory of suggestion in its bearings on therapeutics we find a full confirmation and explanation of the conclusions just reached. It is impossible adequately to discuss this subject here, and reference may be made to an essay on it in my "Papers on Psycho-Analysis." It is necessary, however, to say something about it at this stage, and the remarks made will be amplified later when we come to consider some allied problems in connection with more complex forms of treatment.

Bleuler, Lipps, and others have shewn that the effect of "verbal suggestion," *i.e.* of the conveyance of a given idea to the patient's mind through the procedure of suggestion, is essentially due to an emotional process ("affective suggestion"), to the evoking of an affective state by the personal influence of the physician. We have therefore to investigate the characters of this state, and the conditions under which it may be aroused.* Much light is thrown on the nature of affective suggestion by regarding it not as a peculiar mental phenomenon having no resemblance to any other, but rather as merely a special variety of more general tendencies of hysterics, and, to a less extent, of normal people. When it is studied from this point of view it is seen that affective suggestion, which is the basis of therapeutic suggestion, is simply one manifestation of a more general mechanism called by Freud "transference," that this in turn is a particular variety of what Ferenczi has recently termed "introjection," and that this finally is a characteristic form of the "affective

* Attention is here strictly confined to the idea of therapeutic suggestion, which is obviously narrower than the social conception of suggestion discussed by Le Bon and other French writers, and Trotter and Hart in this country.

displacement " the excessive activity of which is so typical of hysteria.

The ideas connoted by these terms are already familiar to the reader from our earlier discussion (pp. 32-41), and it will suffice briefly to recall them to his attention. It was there pointed out that what is called the inadequate emotional reaction of hysterics, such as the excessive feeling they may display on apparently trivial occasions, is really due to their having " displaced " a quantity of affect from one important idea (primary situation) on to another less important one (secondary situation) which in some way resembles the first, and so (unconsciously) reminds the patient of it ; the example chosen above was that of the child who dreaded all doctors' visits because he had been hurt on the occasion of one of them. " Introjection," a form of this, denotes the tendency of the patient, particularly marked in hysteria, to incorporate the environment into his own personality, to " take things personally," and thus to widen his own ego. Such a patient, at seeing a singer or reciter falter, may experience agonies of embarrassment himself ; he unconsciously identifies himself with the person on the stage, who thus in his imagination becomes a part of his ego, and he feels for him just as though it were himself. This is the explanation of much of the well-known sensitiveness of neurotic people, particularly for suffering. The most interesting introjective manifestations are those relating to the persons of the environment, as in the instance just given. The patient introjects everything relating to them into his own ego, and transfers on to them various affects, love, hate, and so on, born within himself, and which arose,

perhaps years before, in connection with quite other people ; he lives over again the same emotion in the presence of a person who in some way resembles one formerly associated with this, thus identifying the two persons in his mind.

The term " transference " is applied to this process on the occasion when it happens in relation to the physician. The facts of transference are a matter of direct observation, and the conception of it is a direct description of these facts, not an inference from them. It was pointed out above that the changeability and capriciousness so often shewn by the patient in this respect is due to the idea of the physician becoming identified in his mind with that of various other people in relation to whom the affects in question, which are still living, had arisen ; something in the physician's behaviour or appearance unconsciously reminds the patient of some previous person of psychical significance to him, and he reacts towards him as though he really were this person. As is well known, the affects thus exhibited may be of all possible kinds, dread, jealousy, affection, resentment, and so on. " Affective suggestion," however, refers to the state of *rapport* subsisting between the patient and physician when the affects transferred by the former are only those of a positive kind, sympathy, liking, friendship, attraction, or even love. The essential basis for the successful working of any therapeutic suggestion is this *rapport* between the two individuals concerned, produced by the transference on the part of the one person of various positive affects.

The way in which treatment of hysteria by means of suggestion brings about the results it does can be properly

understood only when it is realized that the underlying causes of the malady relate to various disturbances—erroneous development, etc.—of the same positive affective processes as are operative in establishing the *rapprochement* by means of which therapeutic suggestion becomes possible. In hysteria these affects are being manifested in the form of symptoms, which constitute the expression of their activity. In the treatment they are, as it were, withdrawn from this mode of manifestation, and satisfied by preoccupation with the idea of the physician and the feeling of attraction for him. This accounts for the familiar observation that patients treated in this way are apt to become unduly dependent on the physician. Some remain well when the treatment ceases, but many more experience later a renewed need either for another course of the same treatment or else for some similar situation in which a gratifying affective *rapprochement* is possible; the last remark explains why it is that many patients feel better whenever a sympathetic person takes a deep interest in them, or when they fall in love under happy circumstances.

These considerations also make it plain why treatment by suggestion succeeds so much better in some cases than in others, and why the beneficial effect is more durable with some than with others. The recent, temporary, or changing symptoms, the ones most easily “cured,” are usually those that are providing only a partial and unsatisfactory outlet for the pent-up positive affects; the more durable and constant symptoms, which are notoriously harder to remove, are proving more adequate outlets for them. In the successful cases it has been

possible for the *rappport* of suggestion to withdraw the affects from the channels in which they had been flowing, and to attach them to the more suitable idea of the physician's person. When there has been no success at all, this idea has not proved strong enough to attract the positive affects, *i.e.* the patient finds the physician "unsympathetic," and as a rule soon leaves him. When there has been moderate or only temporary success, the idea has been sufficiently attractive to withdraw for a time the affects from their old channels, but when the *rappport* is no longer sustained by constant intercourse and mutual interest between the two persons, the counter attraction of the old routes proves too strong, and the patient relapses into his previous condition. The reader may wonder at the amount of importance here attributed to the part played in the patient's mind by the idea of the physician's person, and the close relationship of this to the positive affects mentioned above. It is a matter to be judged not merely by ordinary observation, but by the evidence revealed by searching methods of mental investigation of patients who have been treated by suggestion ; when this is done, no doubt remains as to the prominence and significance of the part played by the idea in question. The reason is, as Ferenczi first pointed out, that the affects transferred to the physician originated in connection with the most important persons in the individual's life, namely, the parents ; in the case of the neuroses these affects are concerned with the deepest causes of the malady.

Suggestion thus means the interposing of a competitive force into the situation, and the outcome depends on the relative strength of this new force and the old tendency

towards the production of symptoms. Permanent success by means of such treatment signifies that, after the pathogenic affects have been withdrawn from the old channels, the patient has been able to divert them from the idea of the physician and apply them to other, social or personal, interests, *i.e.* to achieve the aim of the "side-tracking" method. That this unfortunately does not happen more often is because the wider interests in question are rarely so attractive to the patient as the other two outlets for his feelings, namely, the phantasies that lie behind the symptoms and the idea of a given person ; he is therefore more likely to hover between the latter ones than to exchange them both for the first.

Conclusions.—In conclusion it may be said that both practical and theoretical considerations support the same judgement—namely, that the great disadvantage of any form of treatment by means of suggestion is the blind nature of it. It achieves its results by substituting the idea of the physician for the previous expressions of the pathogenic affects ; psychologically this signifies merely the replacement of one symptom by another, abnormal dependence on the physician, since in both cases the manifestation (neurotic symptom or dependence) is a symptom of a dissociated complex charged with pent-up affects. In favourable cases this replacement can enable the patient to divert the morbid tendencies into healthier directions, thoughts and feelings about the physician serving as a half-way stage between the original attachment of the affects in symptoms and the desired one in social activities. It is never possible, however, to predict which patients will be able to accomplish this and which not, because the

ætiological complexes have never been dealt with, and therefore never resolved. The underlying tendencies are just the same after the treatment as before, so that it is largely a matter of "chance"—*i.e.* of the strength of these tendencies, together with external circumstances—whether the patient will remain well or not. It is only when these have been liberated from the dissociated complexes containing them that they can surely be diverted into useful channels; failing this it only needs an increase in the painfulness or lack of attractiveness in the environment to make the patient once more withdraw the affects he has been enabled to pour into useful outside interests, and to employ them once more in the production of neurotic symptoms. Other methods presently to be described aim at altering these underlying tendencies by giving the patient a direct personal control over them, by setting free the energy which certain factors have retained in these morbid directions, and by rendering the patient completely independent of the physician and immediately responsible for his own fate.

As regards, now, the field to be reserved for treatment by suggestion, I find with increasing experience that this becomes harder to define. At first I was of opinion that suggestion was especially applicable to the early and slight cases, and that the more thorough and radical methods might well be reserved for the difficult and severe ones, but at present I am rather inclined to reverse this judgement and say that it is just the former cases that most need radical measures, on the grounds that an incalculable number of severe cases would thereby be prevented, and that the gain is greater with the milder cases; with these

one should count on restoring a useful citizen to the fullest activity, whereas with the severe cases one is lucky to be able to rescue the patient from misery and often cannot hope for much more. One becomes more and more impressed with the difficulty of dealing with severe cases, which there is every reason to believe could have been relatively easily cured if only a serious treatment had been undertaken at an earlier stage. I am bound to say that in hysteria, and still more in other psychoneuroses, treatment by suggestion rarely seems to me to offer any advantage over more radical methods, certainly not when all the considerations bearing on the matter are taken into account. One would regard it as appropriate, therefore, only in the event of better methods not being available, such as is still the case in hospital practice, as was the case during the War, or in the presence of factors contra-indicating more radical methods of treatment, such as advanced age, lack of intelligence, and so on.

Though not strictly germane to the present topic, it may be of interest to point out that the disadvantages attaching to treatment by suggestion do not apply, or apply only to a very limited extent, in the case of organic disease, and, in my opinion, this will be the most fruitful field for the method in the future. Three examples of what is meant may be given. Probably in all cases of severe organic disease neurotic factors become superadded in the course of time, so that part at least of the suffering can be remedied by mental measures. If the illness is a chronic, incurable one, of which cancer is the best example, the objection to treatment by suggestion mentioned above, namely, that it leads to dependence on the physician,

does not carry much weight in comparison with the relief that may be afforded by means of such treatment, and there is no doubt that the life of the patient can be made much more tolerable in a number of cases where the additional neurotic element is prominent ; chronic heart disease and advanced tuberculosis are further examples of the same type. The same objection to suggestion is also not serious in certain acute conditions. It has often been used ever since Esdaile's day for producing anæsthesia, and thus permitting surgical operations to be carried out. The practical obstacles in the way of this, such as the long course of preliminary treatment necessary before sufficiently deep anæsthesia can be induced, have prevented this application of suggestion from attaining any wide vogue, but short of this there are many less ambitious uses to which the method may be put in connection with surgery. Of these may be mentioned the securing of a preliminary calming effect before the administration of a general anæsthetic, the value of which is often surprisingly great both for the anæsthetizing procedure and for the subsequent well-being of the patient, and a similar application in connection with minor surgical measures, such as the dressing of wounds and burns, slight operations without a general anæsthetic, etc. ; naturally these remarks, apply especially to neurotic patients. Finally may be mentioned the case of a short, critical illness, such as pneumonia, where the mental attitude of the patient often plays a part of undeniable importance in turning the scale in favour of recovery. This field of suggestion in reference to organic disease has not yet been systematically investigated, but I am convinced that it is a fruitful one,

and one worthy of more consideration at the hand of the general practitioner than it has up to the present received.

III. RE-EDUCATION

We have seen that treatment by suggestion essentially consists in opposing to the forces making for neurosis another set which are derived from the emotions generated through the personal relation of the patient to the physician. Certain of the sub-varieties of it, notably the persuasion and side-tracking ones, form a transitional bridge leading to the present group of methods. These differ very considerably from treatment by pure suggestion, since they aim much more at modifying the pathogenic factors themselves rather than merely neutralising their effect, and attempt to compass this by making use of forces already present in the patient's mind. The principle underlying the re-educative methods is the modifying of the pathogenic tendencies by *linking them up with* others which experience has shewn can exert a beneficial influence on them. The hypothesis on which it is based is, broadly put, that hysterical symptoms are due to the action of psychical traumata, such as shock, fright, grief, etc., on a sensitive organism, and that the effect of these traumata needs to be removed by linking up the memory of them with less disagreeable emotions. Those who employ the method are all workers who have carried out more or less detailed studies on the nature and development of hysterical symptoms, and they all agree in establishing the following feature, among others, in regard to them : that all such symptoms are based on amnesias, *i.e.* that

behind the actual symptoms, and operative in the production of them, are various mental processes which have been forgotten by the patient. So much stress do these writers lay on the matter of amnesia that most of them describe hysteria as essentially consisting in a dissociation, or disaggregation, of mental processes, a sort of multiple personality in miniature, and regard the cure of it as a synthetizing of these disaggregated foci; one form of treatment in the present group is actually called "psycho-synthesis." This introduces another point of view, and renders the task of modifying the pathogenic tendencies a less simple matter than it might at first have appeared, for obviously it would be unsatisfactory to confine oneself to the superficial manifestations, to the end products of the morbid process, and leave untouched the disaggregated foci themselves of which these are the expression.

The discovery of the underlying amnesias in question, first made in 1878 in connection with certain anæsthesias, put a completely different aspect on the problem of hysteria and its treatment. It would seem that, if hysterical symptoms are *dependent on* the splitting off from consciousness of various buried mental processes, the essential and most important step of any radical treatment should consist in resuscitating the forgotten memories, in fusing the dissociated mental processes with conscious ones. Curiously enough, none of the writers now under discussion draw this apparently obvious conclusion, or at all events only with very considerable modification. They hold in general that this resuscitation is frequently desirable, but by no means always necessary, and never sufficient in itself. We shall see later that another group of workers,

on the other hand, adhere to the conclusion in its original form—namely, that all efforts should be concentrated on achieving satisfactory fusion of the dissociated mental elements with consciousness—and also that there are definite reasons why those of the present group, who acknowledge the dissociation principle in theory, have failed to draw the logical inference from it.

Re-education.—There are some differences in the actual methods used by the individual members of this group, so that it is expedient to say something about each in turn. It will be understood that none of them confines himself to any particular procedure, the methods of treatment naturally varying according to the case ; nevertheless there are some characteristic of each worker. We may begin with the earliest worker in this field, Pierre Janet. Janet carefully traces out the life-history of the symptoms present, especially noting any traumatic emotional experiences that stand in connection with them. In doing this he chiefly relies on exploration during hypnosis, in which state, as was remarked above, the field of memory is commonly wider than in the waking state. He also makes use of other methods for the same purpose, particularly those that have been devised, chiefly in connection with “ psychical research ” of mediums, for the investigation of subconscious mental processes. Examples of these are automatic writing and crystal-gazing. In the former the patient’s attention is distracted, for instance by conversation, while his right hand, into which a pencil is slipped, rests on a *planchette* ; in suitable cases, and under favourable circumstances, the hand will proceed to write either connected or disconnected phrases without

the patient's being aware of what is written, or even of the fact that he is writing at all. In the second example the patient, who must be in a state of relaxation and calm, is told to gaze steadily into a clear crystal, or indeed at any shining surface, such as that of a basin of water (lecanomancy), when mental pictures may appear, projected on to the surface gazed at. In both cases memories may be obtained, often in a distorted form, that were inaccessible to the patient's consciousness. The direct and evident memories resuscitated in this way constitute only a small part, and not the most important one, of the buried material actually present, and, further, neither Janet nor any other of the authors mentioned in this group were able to devise any method for sifting and making use of the distorted part of the material. By means of psycho-analysis, however, this can now be accomplished, as has been shewn in most detail by Silberer.*

Janet does not hesitate also to employ verbal suggestion to the limit of its capacity ; in this way he attempts to diminish the intensity of the various emotions revealed by the investigation, thus endeavouring to counteract the harmful influence of these. Perhaps his most characteristic procedure is that termed the method of *substitution*. On finding a given idea associated with an emotion in such a way as to produce morbid effects, he dissects the complex of mental processes, replacing one or more components of them by a fresh idea or emotion, and thus changing the old associations. For instance, if the unpleasant memory discovered was that of a corpse by which the patient had been greatly frightened in childhood, he

* Silberer, "Zentralbl. f. Psychoanalyse," Jahrg. II.

might attempt to invest the memory-complex with agreeable emotions and ideas, the sight and odour of flowers, the sound of pleasant music, and so on, with the aim of robbing it of its unpleasant and morbid associations. Gross substitutions of the kind instanced are of course most easily or effectively carried out by means of powerful hypnotic suggestions.

Morton Prince, who was the first, in 1891, to use the term "re-education" in this connection, proceeds along similar lines, with relatively unimportant deviations so far as principle is concerned. The chief difference between his methods and those of Janet resembles that between persuasion and suggestion, in that he relies less on the grosser forms of substitution and appeals more to the patient's reasoning powers; in a word he treats him more as a rational being than Janet does. From this point of view his methods must be recognised as constituting a distinct advance on Janet's, especially so far as the aim is concerned, but it is probable that the effects are achieved by very similar means in the two cases. The means of preliminary investigation he employs are, with certain unimportant amplifications and modifications, the same as those used by Janet. Having discovered and defined the pathological processes, with the psychical traumata of the past, he exerts himself to explain the significance of them to the patient, to introduce new points of view into the mental processes in question, to present different aspects of them to the patient, to invest them with fresh emotions and ideas, to stimulate the patient's general interests, and, generally speaking, to broaden his mental outlook.

Causal Analysis.—Oskar Vogt described in 1899 a method to which he gave the rather confident name of causal analysis. It consists in a systematic introspection carried out during a state of narrowed consciousness (sub-hypnosis), and can be performed only by persons who have previously been trained in accurate self-observation. The method was devised for the scientific investigation of ætiological problems rather than for therapeutic purposes, and Vogt considers it applicable for the latter in only a very small number of cases ; it may be added that, owing to the inherent limitations of direct introspection, the method has made no contributions of value even to the problems for the study of which it was devised. Vogt would restrict the use of it to a few carefully selected cases, and even then would employ it only after every other therapeutic measure has failed. In general he holds that a detailed investigation of the patient's mental processes is unnecessary except in rare instances, and confines himself to simpler methods of treatment such as those described in the preceding section.

Hypnoidization.—Boris Sidis lays great emphasis on the value of hypnoidization, a procedure that was discussed above in connection with the varieties of hypnotism. When this state has been induced the patient has to mention all the thoughts and memories that occur to his mind, just as had been recommended some years before by Breuer and Freud. He maintains that the beneficial results obtained in this way are due to the pathogenic dissociation being remedied by the uprush from the subconscious of potential mental energy, which automatically brings about a fusion or synthesis of

previously dissociated elements ; the hypnoidal state is supposed to favour this uprush.

Psycho-Synthesis.—Bezzola has given the name of psycho-synthesis to a form of treatment that is practically identical with the “ cathartic ” method devised by Breuer and Freud, and which the latter subsequently expanded into the modern psycho-analysis. Beyond the change of name, and the determination to abide by the imperfections and crudities of the earlier method, there is no original contribution of Bezzola’s to be noted. Frank, De Montet, and a few others have joined him in adhering to the cathartic method, though they prefer to use, unjustifiably, the term psycho-analysis.

Autognosis.—This name has been invented by William Brown to denote the defining of the erroneous trains of thought in a patient’s mind, but he has added nothing new to our knowledge of how to accomplish this.

Anagoric Psychotherapy.—This method, advocated by Adler, Jung, Maeder, and Silberer, is considerably more elaborate and ambitious than any others of this group. Because of its peculiar relation to psycho-analysis it will be better to postpone the description of it until that method has been considered, and it is mentioned here only for the sake of completeness.

GENERAL CRITICISM OF THE RE-EDUCATION TREATMENT

In the first place, it is to be noted that this system of treatment represents a decided progress in comparison with that discussed in the preceding section, for, in contradistinction to this, it sets itself the difficult task of dealing with the pathogenic factors themselves rather than with

their end-products alone. In addition to this we find our "activity" criterion much more pronounced here than there, for the patient is asked to make the effort to review the morbid tendencies in the light of new considerations, and to assimilate in consciousness various forgotten traumatic memories. The aims of this system are, therefore, both more ambitious and more satisfactory than those of the other, for it deals more satisfactorily with the disease process. Although it is not an easy matter to judge, it seems probable that from the practical side also the results achieved surpass those obtained by means of suggestion alone, especially in regard to durability.

In attempting to formulate a complete rationale of the re-education system of treatment we are at once confronted with the circumstance that it involves a different conception of hysteria from that on which the suggestion treatment is based, and it becomes necessary to try, if possible, to harmonise the two points of view. In the earlier of these, discussed in connection with suggestion, hysterical symptoms were regarded as being actively produced by various pathological tendencies in the patient, though the origin and nature of these tendencies appeared ill-defined and obscure. Some of them were thought to be purely of external origin, harmful suggestions implanted in a specially susceptible mind; the main ones, however, seemed to represent more or less egocentric strivings, half-conscious devices for obtaining personal ends, love of simulation as such, desire for sympathy, and so on—in a word, various internal tendencies. The number of those who employ therapeutic suggestion is so great that the actual opinions they hold concerning the nature of

these pathological tendencies vary to a considerable extent, but most of them agree in this highly important particular—that they look upon the tendencies in question as being something of a dynamic nature, as active processes consciously or unconsciously struggling for expression. In consequence of this view, treatment by means of suggestion is felt essentially to consist in the opposing of an external force, which we have traced to the affective influence or attraction derived from the idea of the physician, against the morbid forces that lead to the production of the symptoms. The treatment is thus an interplay of forces, and success depends on the relative strength of each.

The other point of view, with which the re-education hypothesis is identified, seems at first sight incompatible with the former one, which it apparently ignores by substituting a more static conception of the morbid process for the dynamic one there involved. The symptoms now come to be regarded as the after-effects of various psychical traumata, shock, fright, and so on, the memories of which act as if they were irritating foreign bodies. Instead of the emotions natural to these traumatic occasions fading with time, as in the normal, and gradually ceasing to produce their distressing effects, they continue to act, retaining their vitality to a most unusual extent. That the normal fading really does not take place in such cases can often be clearly demonstrated in concrete instances; when the forgotten memory of the experience is resuscitated, the accompanying emotion is found to be just as intense and vivid as if the experience had occurred a moment before, instead of years ago. This finding may be correlated with the conclusion reached in the discussion of the

general management of hysterical cases, namely, that the past life is still active to an abnormal extent, and that in a sense the patient is still largely living in the past rather than in the present. The fact that the old emotions retain their effect in such an abnormal way is thought to be explained on the present hypothesis by invoking a general constitutional defect in the patient, due to inherited predisposition, faulty education, perhaps physical ailments, and other less important factors ; the actual nature of this defect, however, is left rather vague. In the next place the re-education point of view lays more stress than does the first on subconscious morbid agents, maintaining that the effective mental processes giving rise to the symptoms are for the greater part unknown to the patient ; in other words, the traumatic memories, though still active, have been forgotten. This consideration is brought into line, particularly by Janet, with the conclusion just mentioned by assuming that hysterical patients have an inborn tendency to mental dissociation, or, put in another way, that they have a congenital incapacity for assimilating in consciousness various experiences that the normal can—a defective power of synthesis.

It will readily be seen, and this is an important consideration, that the second point of view brings with it a much more sympathetic and tolerant attitude towards the patient than the first. There is no longer any question of reproach for selfishness or moral obliquity ; at the worst there is only a contemptuous pity for the deficient power of resistance shewn. There is no feeling that the patient is half responsible for his condition, and certainly none that he has brought it on himself. On the contrary,

the facts that the patient is really unaware of the causes of his symptoms, and that these have arisen through the action of painful traumata on a defective mental constitution, make him the unfortunate victim of circumstances over which he has not the slightest control, a plaything of fate in need of help and sympathy. The difference in attitude follows logically from the difference between the internal, dynamic view of hysteria as a condition produced by a perverse will and the external, static one as a condition due to unhappy accidents.

The foregoing remarks shew that there is a considerable opposition between the points of view represented by the suggestion and re-education systems of treatment respectively. It is here maintained that each of these contains a distinct body of truth, and, if this is so, it is plain that neither can be regarded as furnishing a complete theory of hysteria, since each ignores certain aspects of the problem. The imperfections in the hypothesis underlying the suggestion treatment have been mentioned above, and it remains to discuss those of the re-education one. It may in general be said that they are due to theory outstripping practice, and that they can all be traced to inadequacies in the methods employed for investigation and treatment.

Three distinct respects in which the hypothesis under discussion must be regarded as incomplete may be presented. (1) The first is that it does not take into sufficient account the dynamic features of hysteria that were pointed out above. Granted, for instance, that the patient is essentially suffering from the results of an old psychical trauma, it is not clear why he should exploit this in his own interest to so much greater an extent than any one would a physical

trauma. Further, purposefulness, *i.e.* the action of a will, is much more prominent a feature in the unconscious factors operative in the causation of hysteria than in the conscious ones discussed above, and here it has been almost entirely overlooked by the writers in question. (2) The second is that, although the ætiological factors discovered by the methods used in the preliminary exploration throw much additional light on the past history and pathogenesis of the symptoms, they afford only a very partial explanation of them. This matter can only be discussed here in a few words, for it is more directly concerned with psychopathology than with therapeutics, but the following example may make the point clearer. It may happen that the investigation of a given symptom discloses it to be historically connected with a certain trauma; thus, a tremor of the right hand may be found to have first appeared at the moment of a great fright—the memory of which had been forgotten—and to have persisted ever since. Now even though the trauma is accepted as being an ætiological factor of considerable significance, the finding in no way explains why precisely a tremor rather than a paralysis, and why a tremor of the right hand in particular, should have resulted, or why any symptom at all should have followed this particular trauma and not other ones, which were often apparently more severe. Many of the findings reported indicate a closer inherent connection between the nature of the trauma and the symptom than is here indicated, but the example—a crude one is purposely chosen for the sake of simplicity—illustrates the kind of inadequacy referred to. In any such investigation carried out by the methods

in question one can always point to features not explained by the findings, questions left unanswered, and problems not cleared up. (3) The third respect is that the hypothesis does not make it plain why, if the essence of hysteria resides in dissociation and recovery denotes synthesis, the fusing of the dissociated elements is not sufficient for recovery. According to the dissociation hypothesis it might have been expected that this should be all that is necessary, while according to the unanimous experience of the writers belonging to the present group it needs to be amplified by other procedures, such as substitution, suggestion, and so on. The reason for this contradiction between theory and practice is to be found in the consideration last adduced, namely, that the investigation of the dissociated elements has always been incomplete, so that the fusion accomplished has always been an imperfect one and inadequate in itself for the therapeutic aim. Without doubt the fault of this lies mainly in the technique of the investigation, for it can be shewn that none of the procedures mentioned above is capable of penetrating beyond a certain definite limit into the buried mental processes of the unconscious. It is generally recognised that the pathogenic factors, even in the case of a single symptom, are probably always multiple, the symptom being the end-product of them all, and not the result of simply one causative agent. It is possible, indeed it is easy, for an investigation to disclose only some of these factors; the less important ones are usually laid bare first, being the more superficial and accessible. The complete unravelling of the pathogenesis of an hysterical symptom is a much more ambitious task than is commonly

supposed, and many workers have been too readily content with their first findings, which, as was just mentioned, are generally the least important.

Conclusions.—In conclusion, it may be said that the studies connected with the re-education system of treatment afford a deeper insight into the origin and nature of hysterical manifestations than do those of the suggestion system, and that they open up a fresh series of problems having a direct therapeutic bearing. They do not, however, furnish us with any satisfactory solutions of these problems, and their imperfect success can be traced to the incompleteness of the investigations carried out by the methods in question. Both of the two hypotheses, relating respectively to these two systems of treatment, must be regarded as one-sided, inasmuch as they both concentrate attention on certain aspects of the problem to the exclusion of others. The second hypothesis is more comprehensive, and nearer to the full truth, than the first. With it we see introduced a highly important therapeutic principle, that of fusion of previously dissociated elements, one radically differing from that of suggestion, and with which we shall have to concern ourselves further.

The workers belonging to the present group were unable to carry this principle to its logical conclusion in therapeutics because of the insufficiency of the exploratory means at their disposal, so that a full re-synthesis was out of the question; it was only when a more satisfactory method of procedure was perfected that it became possible to make the principle fruitful as a practical therapeutic measure, and ultimately to solve the various problems raised by the different modes of approach. Baffled in

their endeavour to base a satisfactory therapeutics on the traumatic, static hypothesis, they fell back in practice on the potent instrument of suggestion, the use of which they deliberately developed. It is highly probable that a great part of the therapeutic success achieved by exponents of the re-education methods is due to the effect of suggestion, either to direct verbal suggestion or to the affective *rapprochement* between physician and patient through which this obtains its power. No doubt some of the beneficial results are also to be attributed to the synthesis of dissociated elements, however partial, to the unloading into consciousness of pent-up and buried emotions, and to the insight and control that the patient attains by being given a broader view of matters that had previously disturbed his mind. Probably the greater part of the success, however, is produced by the action of suggestion, which can operate all the more efficiently since the pathogenic factors against which it is directed are to some extent more accessible and better understood; it consequently presents—though in a lesser degree—the same inconveniences and defects of uncertainty as to future evolution, instability, and so on, that were discussed in the preceding section. It was reserved for the system of treatment next to be described finally to eradicate these deficiencies inherent in the influence of suggestion, to reconcile the conflicting methods and aims of therapeutics, and adequately to base the treatment of hysteria on rational knowledge.

IV. PSYCHO-ANALYSIS

This method, devised by Sigmund Freud primarily for the elucidation and treatment of hysteria, has proved

to be of much wider applicability than was at first thought likely or even possible, so that it will have to be treated more generally than the other methods of more limited scope and pretensions. By means of it problems of the other psychoneuroses, of insanity, and of normal psychology have been investigated in great detail. Further, the use of it has not been confined to the study of the present, but has been extended also to that of the past; this refers to the psychology both of the individual, for instance of geniuses and historical personages, and of the people, in the form of mythology, philology, anthropology, and folk-lore. A consequence of these comprehensive researches has been the widening of our knowledge of mental mechanisms in general, and the introduction of new conceptions of psychology—indeed, well-nigh the creation of a new psychology. The knowledge gained from these other fields, which at first sight seem to have nothing to do with hysteria, has been of very great value in the study of even the narrower problems of the neuroses, and has shewn the continuity subsisting between all the manifestations of human imagination, healthy or disordered. Both the widening of the subject-matter and the novelty of many of the conceptions render the task of presentation in a limited space a peculiarly difficult one, and to restrict oneself to the therapeutic problems alone would almost certainly be to court unintelligibility. It is hoped, however, that it may be possible to present with sufficient clearness at least the main principles of the subject, and so as better to attain this a general account will first be given before proceeding to a description of the therapeutic method itself.

We may begin by developing to a further stage some of the considerations already made familiar in the previous sections, it being understood that the conclusions enunciated—constituting part of what is known as Freud's theory of hysteria—are based on investigations carried out by means of the psycho-analytic method. In the first place may be mentioned the respects in which these investigations confirm general inferences drawn from other sets of observations. Freud fully agrees with the findings expressed in the re-education hypothesis, that every hysterical symptom is built on an amnesia, or rather a series of amnesias, that the pathogenic factors producing the symptom consist of a number of mental processes of which the patient is for the most part entirely unaware, and that among these mental processes are commonly, though perhaps not invariably, to be found the buried memories of painful (traumatic) experiences. The conception of unconscious functioning of unconscious mental material is thus an essential part of the theory. Freud is not content, however, with the assumption that the pathogenic influence of the traumata is due to their having acted on an unstable mental disposition, though it is evident that some second factor must be in operation, if only for the reason that exactly similar traumata produce no pathological effect on other people. Instead of invoking as the second factor a vague constitutional inferiority, he examines the question by seeking to define the precise way in which the patient reacted to the traumatic experience, and study of this discloses certain peculiarities of the hysteric mode of reaction as contrasted with that of the normal.

One of these peculiarities is that the patient behaves towards the thought of the experience just as though it were something to be ashamed of, and often as though he himself were responsible for its occurrence ; he will not talk of it, dislikes to think of it, is afraid to face the idea of it, and tries to " keep it from his mind," or, as it is technically called, to " repress " it. It is as if he had been prepared for the experience by previous mental activities not present in the normal, as if it reminded him in some apparently unintelligible way of previous thoughts the existence of which he did not care to avow ; this impression is shewn on further investigation to be well founded. A clear example of the kind of thing that may happen would be that of a girl who had for some time been indulging in sexual phantasies, had pictured to herself, half shudderingly, half fascinated, what it would feel like to be assaulted, and then actually was assaulted. It is comprehensible that the reaction of such a girl towards the trauma is different from that of another person ; her phantasy, or ill-defined desire, has been realised, and she has a sense of guilt as though she were half to blame for the situation. It is a typical behaviour of such a girl not to mention the experience to any one, not even to her mother, and it has been established by observation that children who conceal such experiences are more likely than others to be the victim of more than one of them ; they are apt to wander, not deliberately perhaps, but not altogether accidentally, in localities favourable to the occurrence of such episodes, shewing thus that their subsequent feeling of guilt is not entirely without justification. More traumata (of all kinds, physical as well as psychical) than might be imagined

are in this way half sought for, and persons of this sort are said to have a "traumatophilic" disposition.

While the abnormal significance of such experiences as the one just instanced is sufficiently intelligible without any further explanation, this is by no means so in the case of more innocent and entirely accidental ones; for example; a sudden grief at the death of a loved relative, fright at the outburst of fire, and so on. Still even here Freud has found that the occasion is one that becomes connected with intimate thoughts previously present in the patient's mind, the only difference between these examples and the former one being that the association of the traumatic experience with the preceding mental processes is a less direct one, and therefore more easily eludes the physician's notice. The result of such investigations is thus to throw the accent not on the traumatic experience itself, but on the previous development of the patient's mind, the discovery of the trauma being regarded mainly as a starting-point for further exploration of the origin of his attitude towards it, and not merely as an explanation of the symptoms succeeding it.

Working along these lines Freud noticed that the mental processes connected with the symptoms, and also with the traumatic memories when these were present, always included private thoughts that the patient was either aware of, but extremely unwilling to mention, or else that he was strongly disinclined to admit the existence of even to himself. The reason for the patient's attitude was plain enough: the thoughts were of such a kind as to be incompatible with his "higher" ideas of propriety, of duty, or of morality, and were thus unacceptable to his

conscious self. These inhibitions, the tendency of which is to banish and keep certain thoughts "from the mind," *i.e.* to prevent their entering consciousness, Freud groups together under the generic name of "censorship," the analogy between them and the supervising, selecting functions of social and literary censors naturally suggesting itself. The series of observations here referred to solved the important problem of dissociation. Mental processes are dissociated, split off from consciousness, kept "repressed" in the "unconscious," either when they are themselves incompatible with the "higher" social and ethical standards of conscious tendencies, or else when they are closely associated with other mental processes of this unacceptable nature.

In a word, dissociation is the product of the repressing activity of the censorship. As was indicated above, this activity extends far beyond the compass of the mental processes inherently falling under the ban of the censorship, just as in the middle ages when a traitor was banished from his country the sentence was apt to include his family, friends, and all those connected with him; it is as though, in order to be quite sure that the disagreeable thought does not enter consciousness, care is taken also that no associated thought which might arouse the other should enter.

Further research into the nature of the mental processes that determine the patient's abnormal reaction towards any psychical trauma shewed Freud the enormous importance in this connection of the life of phantasy, and, indeed, one of the most prominent features in his psychology in general concerns the relationship and conflict between

phantasy on the one hand and adaptation to the demands of reality on the other. A great part of our whole mental life is built on the contrast between these two tendencies. Whenever any one experiences a need, a desire, an ambition, he is faced with the choice of gratifying it in one of two different ways. The easier, and one might say the instinctive, way is to imagine to oneself that it is already being gratified, to indulge in this phantasy, and to enjoy it in the imagination, a proceeding that is naturally more apt to be preferred when the desire is one the actual fulfilment of which presents difficulties or calls for patient endeavour ; instances are a young man's day-dreams of a prosperous career or of a beautiful and attractive mate. The harder, but more permanently satisfactory way is by bending one's energies to the task of altering the real external situation so as to bring about the fulfilment of the desire in actuality. The two processes are, of course, not entirely independent of each other, for the initial phantasy commonly plays an important part in determining a later mode of action, and also in stimulating the person to undertake this, by presenting to him in a vivid manner its desirability.

Phantasy has played a tremendously significant part in the history of mankind, not only because of the frequency with which external situations and possibilities baulk internal desires, thus leaving phantasy as the only means of gratifying them, but because it represents the most primitive and fundamental form of mental activity, being, therefore, especially characteristic of children and savages. The power of the child's imagination is famed ; to him a hobby-horse is quite equivalent to a horse, a

bath-tub to a pirate ship, and a broom-stick to a soldier's lance. As for uncivilised, or indeed civilised peoples, one has only to point to the universal prevalence of magical and occult procedures which constitute short-cuts to the gratification of various desires. It is not commonly realised how slowly mankind has renounced this method of gratifying its wishes, or how imperfect the replacement of it by the alternate method of adaptation to reality still is. A matter of especial moment is the strong tendency to have recourse to phantasy whenever the desire in question is either difficult or impossible of achievement. A woman who cannot be with her husband because he has just died flies either to the memory of the happy past or to the picture of reunion in a blissful future, the reality of the grim present being unendurable. Only the rarest of minds can truly face reality in all its aspects, and whole nations have had to invent the idea of an imaginary other world in order to make life in this one even tolerable, or at least to afford some recompense for its hardships.

It is commonly recognised that phantasy plays an especially prominent part in the mental life of hysterics, as is illustrated, for instance, by their pronounced tendency toward day-dreaming. Hysteria is, indeed, perhaps the best example of a malady of the imagination. The imagination of hysterics possesses a much greater influence over both their mental and physical functions than is the case with the normal, and this excessive development of phantasy at the expense of adjustment to the needs of reality must be regarded as an important characteristic of the disorder. It is quite common with such patients for an imagined experience to have an equal significance to a real

experience. An imagined trauma, for instance, may have precisely the same harmful effect as a real one, and for this reason it becomes practically irrelevant whether a given traumatic memory, resuscitated from the unconscious by special investigation, actually corresponds with the truth or not ; the effect of it on the patient is the same in the two cases.

Realising the importance of the imagination for hysterics, we can now understand the significance that unhappy experiences have in the development of their symptoms, and also the inordinate extent to which they are influenced by their past. The explanation is that, as was remarked above, unhappiness in actual life, and especially the denial of various desires, always tends to drive the person to indulgence in imagined happiness and gratification. There are several reasons why particularly phantasies from the past life should be resorted to in seeking this form of consolation : it is partly due to the circumstance that they represent one of the two possible escapes from a hateful present, which are, namely, the future and past respectively ; the latter is, of course, the primary one, since all visions of the future are ultimately constructed out of material yielded by memories of the past. A simple and very typical example of the " flight from reality " into a happy past is seen in certain hysterical deliria that are apt to occur in prisons, the patient imagining that he is once again a child sheltered and forgiven by his parents.* It is also partly due to the imperfect

* This matter has been very fully dealt with by Sträussler, " Beiträge zur Kenntnis des hysterischen Dämmerzustandes.—Ueber eine eigenartige, unter dem Bilde eines psychischen 'Puerilismus' verlaufende Form," *Jahrb. f. Psychiatrie u. Neurolog.*, Bd. xxxii. Heft 1 u. 2.

renunciation of past pleasures that is so characteristic of the hysteric, and which makes him shirk adjustment to a new reality even more markedly than the normal does ; a crude example of the attraction of past enjoyments is when persons relapse into old habits of masturbation after the death of their partner.

A moment's consideration shews that the essential content of any phantasy is a desire, or rather the fulfilment of a desire. This applies to the fanciful "castles in Spain" with which we are all familiar, as well as to the more practical ambitions that play a prominent part in so many people's day-dreams ; in the imagination all the heart's desires may be gratified. Freud describes the mental processes effective in the production of hysterical symptoms as *wishes*, using this term in rather a broad sense as denoting all kinds of longings, desires, and strivings, the gratification of which can be represented as a definite goal, *i.e.* as synonymous with what English psychologists would call conative trends. Indulgence in the imaginary gratification of them is evidently pleasurable, and it is a common experience of ardently-minded people that the tearing oneself away from such phantasies, and replacing them by the possibly sordid reality of the moment, is by no means always easy. We see here the main reason why the hysteric finds it so hard to give up old phantasies, and why, therefore, he is so much influenced by his past ; it is because of the difficulty of renouncing old pleasures, especially when the real present has nothing to offer that is comparable in delight. Careful analysis of the symptoms shews that they represent, in a distorted and at first sight unintelligible form, an imaginary gratification of secret

desires. In other words, they constitute a *symbolic wish-fulfilment*. The explanation of why they are presented in a distorted guise will be considered presently.

It is difficult to overestimate the significance of this conclusion, which illuminates many of the most complicated problems of hysteria. It explains at once, for instance, the curious features that were discussed in the section on general management, namely, the way in which the patient clings to his disease, the way in which he exploits and draws gain from it—this is the very meaning of the symptom—the frequency with which he appears to simulate or even manufacture symptoms, and his unmistakable reluctance to get well. It thus allows a certain justification for the unsympathetic attitude that commonly accompanies the observation of these facts, since it teaches that the patient produces the symptoms for his own personal gain and pleasure. It lays stress, however, on the circumstance, of cardinal importance, that most of the processes go on in the patient's unconscious without his being at all cognizant of them, which evidently must be taken into consideration in reference to the question of responsibility. We see here once more an example of the way in which the two hypotheses of hysteria previously described each contain a modicum of truth—corresponding to the unsympathetic and sympathetic attitudes respectively—that this is greater in the case of the second hypothesis, but that neither contains the whole truth. Again, the conclusion in question neatly reconciles the dynamic and static views considered above, for, while admitting with the latter the importance of the traumatic experiences, it points out that the underlying process

giving to these its importance is a dynamic one, consisting in the active building-up of symptoms out of the material yielded by such experiences, in response to various striving desires. It need hardly be said also that from the present point of view the "inadequate" emotional reactions of the patient are fully accounted for, these being determined by displacements from older mental processes now buried in the unconscious, the affects from which go to reinforce and "exaggerate" those evoked by the actual situation.

To look upon a disease as in any way the expression of wish-gratifications is of course a strange conception, and one not easy for the medical mind to grasp, for all other diseases are extremely unwished-for occurrences. It is not obvious how any suffering can bring pleasure, and be produced for this very purpose, still less how a given hysterical symptom, a paralysis or a spasm, can be related to any definite wish. It must not be forgotten, however, that, as was emphasised earlier, psychoneuroses differ very radically from ordinary diseases, and the application of the term "disease" to both sets of phenomena is a matter of custom and convenience rather than an expression of any inherent identity. We must therefore be prepared to expect in this field of study conceptions that are foreign to ordinary medicine. To make clear the detailed connection between specific wishes and the particular symptoms they give rise to would be impossible here, for it would necessitate the relating of a full analysis, thus trespassing too far on to the non-therapeutic aspects of psychopathology. The following brief considerations, however, may throw more light on the matter.

An hysterical symptom, and the mental processes composing it, form an elaborate structure, built up of a great number of different elements. When fully investigated, it is found to contain, not a few ideas and memories, as Janet and others hold, but a considerable section of the patient's deepest mentality ; in many cases the complete unravelling of a single symptom means the laying bare of most of the patient's inner mental life. A symptom can thus express more than one thought, just as any act in daily life may serve more than one purpose and be dictated by more than one motive. Freud gives the name "over-determination" to this process of a symptom being determined by several contributing factors. Sometimes the different factors are convergent, being of different origin, but more typically they represent merely different phases of the same continuous tendency, which are united together by a chain of associations.

As an analogy from daily life we might take the case of a man defending a friend who had committed a social sin, his action being dictated not only by the natural desire to help a friend, but also by the circumstance that he knows himself liable to the same temptation, and that it was this common trait in their characters that first, perhaps unconsciously, drew them together (as might well be the case with, for instance, homosexuality) ; he is really defending himself. Here one sees how inter-related the factors are, and one can describe as the ultimate origin and motive of the conduct in question the presence in the man of that particular trait of character, or, to be still more accurate, the various causes of this trait ; to give a full explanation of the conduct, therefore, would necessitate

a much more extensive analysis than the casual observer, or perhaps even the man himself, might have imagined. One sees, similarly, that in hysteria the different agents producing a given symptom are not co-equal, but are, so to speak, on a series of different levels; the deeper ones are not only older in time, and usually more fundamental in importance, but are less accessible to consciousness and evoke a greater "resistance" (opposition) when they are being explored. In any investigation of them it is only too easy to halt at the first stages, to explore only the upper levels of the mind, and to imagine that one has elucidated the whole matter. In this case the explanation attained will be imperfect in two important respects: in the first place, it will cover only certain aspects of the symptom, leaving others as unintelligible as before; and in the second place, even if certain ætiological factors are actually discovered, it will not make clear the reason why they possess such an unusual degree of pathological importance, for this reason lies farther back in the psychogenesis of the factors themselves. To pursue the investigation to its proper end needs an almost tireless energy and patience, a ceaseless asking of the question "Why?" a restless discontent with the finality of any simplistic explanation, and a determination to discover not merely the cause of the proximate cause, but the cause of this, and so on until the whole structure of the symptom is laid bare. Yet, as will presently be explained, the success of the treatment depends on the thoroughness with which this exploration is carried out, for the more fundamental the aberrant tendency dealt with, the more satisfactory the result as compared with that obtained by dealing only with the late

products of the tendency ; there is all the difference that accrues between tapping the superficial pockets of pus in the case of a riddling abscess and thoroughly laying open and draining the whole series of connected cavities.

This matter of the over-determination of hysterical symptoms has evidently a bearing also on the question of the period of life at which the various pathogenic factors have developed. Freud maintains, as the result of his experience, that all such symptoms can be traced to deviations from the normal occurring in the earliest age, usually in the first three years of life, and always before the fifth. If certain well-defined aberrant tendencies have not been developed before the latter age, then nothing that happens to the person later on can give rise to hysterical symptoms. The importance of this consideration for prophylaxis during these early years is obvious, and will be dealt with separately. The matter has also a bearing on the problem of heredity, for it is customary to attribute to this factor any mental deviation the beginning of which cannot be recalled, the very existence of the important first years of life, for which there is usually an amnesia, being completely overlooked.

In the next place a little may be said about the distortion that the wish-complex undergoes before becoming manifested as a symptom. It was remarked above that special features of this complex are that it is a " repressed " one, that it is in a state of unconsciousness—though none the less active for this—and that it is of such a kind as to be incompatible with the patient's conscious standards of morality or propriety. These features become more intelligible now that we have realised the infantile

origin of such complexes. The young child is not moral or proper to begin with ; he is not immoral, it is true, but he is definitely non-moral, and a great part of his early education consists in acquiring the standards of the adult on all sorts of matters. He is preoccupied to a far greater extent than is appreciated by adults, who have forgotten this period of their life, with bodily functions that are taboo in polite society, he is addicted to habits that in an adult would certainly be described as nasty, and his dawning curiosity is apt to concern itself with questions that he is commonly supposed to be too young to think about ; as for his ethical sense, the egocentricity of the child, his attitude towards property and possession, and his disregard for what is due to others, are proverbial qualities. The hysteric may be said to have retained many of the normal infantile characteristics to an unusual extent, though of course the external manifestation of them is considerably modified owing to educational influences ; like a well-known hero of the juvenile drama, he has " never grown up."

The repressing force of the educational censorship, though it is strong enough to prevent any direct expression of the original tendencies, does not succeed in abolishing their striving for such expression. As a result of the conflict between these two forces a compromise is reached, a mode of expression is permitted by the censorship under protest, as it were, one which embodies the original tendency, but in a veiled form. These compromise-formations constitute symptoms, and they are to be regarded as substitution-products which replace the repressed wish-fulfilment. The construction of them

represents a partial failure and a partial success of the inhibiting forces, described for short as the censorship : on the one hand this fails in its attempt to prevent any expression of the repressed wishes, while on the other it succeeds in preventing any direct expression of these.

In a word, therefore, symptoms *symbolise* wish-fulfilments, and they bear the mark of the censorship. The action of the latter is quite comparable to that of the social censorship of polite society. In circles where ladies do not have legs, they confess to "limbs," and admit that their chairs and pianos have "supports"; every doctor has heard the gastric region referred to as the "chest," the hypogastric as the "stomach," and the genital as the "side." In this way an inherently improper subject may be discussed provided it is hinted at indirectly and delicately enough by means of suitable euphemisms. Hysterical symptoms are just such hints, unconsciously conveyed, and they can be understood only by interpreting them into plain language. It is further clear that the more shocking the topic, or the more rigorous the censorship, the more circumlocutory and indirect will have to be the mode of expression if it is to be permitted; in psychological phraseology, the more intense is the repression the more superficial is the association between the repressed complex and the conscious manifestation of it. A complex that can manifest itself only through illness, incapacity, and suffering must needs be both significant in itself and in a state of unusual repression, and it is therefore perfectly intelligible that most of the connections on which the symbolism is based seem to a normal person to be unnecessarily strained, or even far-fetched. An

example of this kind of connection may be given : Various repressed thoughts relating to the male organ may betray themselves in consciousness by certain exaggerated emotions, particularly fear, concerning the idea of a snake, which thus becomes a substitute or symbol for the former. Now, with the average healthy person no comparison between these two ideas is likely to be instituted, at least in consciousness, and the resemblances between them may well not occur to him until they are pointed out ; further, his emotions concerning the first-mentioned idea will probably be under sufficient control to prevent their radiating, even unconsciously, on to the second one in more than a certain degree. With someone, however, who has an intensely strong emotion concerning that idea, there is enough likeness between it and the other for a close association to be unconsciously established between the two, so that emotion flows over from the first to the second ; the actual resemblances evidently lie in the general shape, in the presence of the peculiar head—often hooded—in the capacity for erection, the habit of ejecting a white fluid—an act followed by serious consequences—the insinuating mode of attack, and other treacherous features common to the two objects. The same symbolism appealed more extensively to cruder civilisations than our own, for in early religions all over the world the snake has been the commonest phallic emblem to be revered and worshipped, and numerous still living superstitions and folk-lore beliefs are survivals from this.

The precise mechanisms by means of which a repressed complex becomes symbolised in consciousness by a given group of mental processes have been investigated, and

are now known in considerable detail. The actual form assumed is never a matter of "chance," but is determined by specific factors depending on the experiences and phantasies of the individual ; they are rarely the same in two people. It is impossible, however, to enter on this extensive subject here, and reference must be made to the literature on the non-therapeutic aspects of psychopathology.

The knowledge of the causes of distortion in the manifesting of unconscious complexes helps to explain the puzzling circumstance that a symptom evidently giving rise to suffering may nevertheless also afford pleasure to the patient. Three important matters have here to be borne in mind. First, that the pleasure or gratification is mainly an unconscious one, since it is chiefly buried and secret desires, foreign to consciousness, that are being satisfied. Secondly, the hysterical symptom is not purely a wish-fulfilment, but a compromise between this and the repressing forces ; while, therefore, the gratification refers to the unconscious wish, the suffering takes most of its origin in the conflict between this and the inhibitions of shame, fear, disgust, and so on, being derived from the upper and more conscious layers of the mind. Thirdly, suffering itself is often a pleasure. The form of sexual perversion, for instance, which consists in a desire to suffer and a delight in pain (masochism), is present also in the normal to a greater or less extent, the expression "he hugs his sufferings" being a familiar recognition of this tendency ; it is more pronounced with women than with men, and is abnormally so in hysteria.

The question may now be asked how this symbolism,

which we have considered up to now purely on its mental side, can express itself in bodily manifestations, such as in the physical symptoms of hysteria, pain, paralysis, etc. No emotion occurs without some somatic accompaniment, such as the muscular tension of anger, the palpitation of fear, etc., and, apart from speech, our only means of expressing any mental process externally is through various bodily movements. These movements are always connected with corresponding ideas in our minds, and when such ideas are assimilated to a complex it can be symbolised by them. In this case a given movement, for instance, walking, may come to represent a complex with which the corresponding idea is indirectly connected, possibly an inability to move—the bowels. This may be put in physiological language by saying that an afferent impulse which is inhibited from finding its normal expression, corresponding to an emotional manifestation, flows along other neural paths, producing the motor effects appropriate to the latter. An hysterical symptom would be like a man shaking his fist in defiance without being aware of any anger, the emotion being dissociated and therefore not conscious.

Freud uses the term “conversion” to designate this replacement of a mental by a physical manifestation, and describes the familiar type of hysteria in which the physical symptoms predominate as “conversion-hysteria.” He considers that there is in hysteria a special predisposition on the part of the body (*somatisches Entgegenkommen*) which makes this process of conversion occur more readily than in the normal; this inference can be related to the cognate fact that with such patients bodily processes are

more extensively influenced by mental factors, especially emotional ones, than is the case with the normal, a matter discussed above in connection with the subject of hypnotism. He also finds that there is frequently a special predisposition of a given part of the body to discharge the energy that is flowing in an aberrant path. The choice of a particular symptom is thus determined not entirely by the mental associations or symbolisms present, but also by the attraction that a given sensitive part of the body, which is perhaps defective or actually diseased, may present towards any symbolic process that is possible. If, for example, the repressed complex can in any way be symbolised by the idea of lameness, it is more likely to become so when the patient already has a lame leg. This finding also is quite in harmony with common experience, for so well known are the local, exciting causes of hysteria that the attention of many physicians, and particularly surgeons, is notoriously concentrated on them to the relative neglect of the more important mental causes.

It was said above that the primary wishes and phantasies ultimately responsible for the production of hysterical symptoms are of an intimate nature and incompatible with the ethical and æsthetic standards of the patient's consciousness. It is therefore not to be wondered at that psycho-sexual factors play a predominating part in the pathogenesis of the malady, especially since phantasy altogether is in its very nature closely related ontogenetically to the sexual instinct, whereas, on the other hand, no mental processes are submitted to anything like the same degree of repression and distortion as those concerning sexuality. There is little actually new in this simple

conclusion, which, indeed, has been suspected from the beginning of medicine, and which is expressed in the very word "hysteria" itself. Freud has formulated the conclusion that every hysterical symptom is built on a repressed sexual wish, and, writing as he has in an age when every nerve is being strained to confine sexuality within the narrowest possible limits, he has encountered as a result a torrent of censure and abuse. To those, however, who sharply distinguish between moral and scientific canons, restricting each kind to its proper field, it is plain that the truth of this conclusion is a question to be decided by the evidence of the facts rather than by any *a priori* preferences, and no one who has made a competent and unbiassed investigation of the facts on which Freud's conclusion was founded has failed to confirm it. Freud of course admits, and it seems necessary to insist on this, that many other kinds of pathogenic factors are also operative in the development of any given case of hysteria, but he maintains that the psycho-sexual one is the specific and only indispensable factor.

Some misapprehension has arisen owing to the breadth of Freud's use of the term "sexual" and his general conception of sexuality, a matter that can be here considered only with the utmost brevity; reference should be made to special writings on the subject. Freud does not confine the use of the term to processes that directly serve the function of reproduction, but would extend it to denote such acts as masturbation, whose main function is evidently to yield a special form of satisfaction and pleasure. This special form, with its specific quality of accompanying sensation, is perhaps difficult to define

accurately, but it is so familiar to every normal being that an exact definition becomes superfluous.

It may now be asked, how is this sexual theory of hysteria reconciled with the stress laid above on the infantile nature of the causative mental processes, phantasies, and so on? The view is still current in scientific circles that sexuality is practically synonymous with reproductive functioning, and hence cannot be present at a time of life before these functions can be fulfilled, *i.e.* before the time of puberty. Freud, on the contrary, discarding this teleological definition, contends that the sexual instinct does not suddenly emerge as a new phenomenon at this age, in the way that is commonly believed, but that the form assumed at this period is gradually evolved from rudimentary elements present even in the earliest years of life. According to him, sexuality is not absent in the child; it is merely different, being imperfectly organised and as yet unadapted to its later functions. This different form, however, characteristic of childhood, deserves the term "sexual" as much as does the adult one. The infantile (childhood) manifestations are, like those of the adult, both mental and physical. Instances of the former are attraction and jealousy in relation to the opposite sex, curiosity regarding sexual topics, and various phantasies and desires, the general importance of which was pointed out above. On the physical side there are the experiencing of and search for pleasurable sensations of a sexual order, which at first are diffusely distributed over the body, the supremacy of the genital region in this respect being not yet established. Certain areas are from the beginning more sensitive than others;

to these the name of erotogenic zones has been applied. Prominent among them are the different orifices of the body, particularly the urinary one and those of the alimentary canal ; one of the latter retains its evident sexual significance even in adult life, as is shewn by the phenomenon of kissing. The functions relating to these orifices are apt to evoke specific pleasurable sensations which in intensity and quality cannot be explained by the mere physiological significance of the functions themselves ; just as adults partake of certain delicacies not merely so as to maintain a metabolic equilibrium, but because they enjoy the taste of them, so an infant may suck a rubber teat not only when he is hungry, but also in a state of repletion, because of the pleasurable sensations excited by the act.

All this primordial mass of pleasurable activities and sensations becomes profoundly modified as the result of growth and education. One part only becomes selected and differentiated so as to form the adult sexual impulse in the narrower sense. A greater part is found to be incompatible with the standards of social observance, æsthetic, moral, etc., and thus comes into conflict with the various inhibiting forces representing these standards. The result of the conflict is that the primitive tendencies are " repressed," buried, forgotten, and with them disappear most of the other mental processes associated with them in time. Freud in this way solves the problem of normal infantile amnesia as well as that of hysterical amnesia ; both are due to the process of repression. The repressed impulses, however, do not die—it is much harder to kill old desires than is generally thought—but continue

throughout life to strive towards gratification, leading an underground existence in that region of the mind which is entirely dissociated from consciousness, the "unconscious." Owing to the permanent and automatic action of the inhibiting forces they cannot attain any direct mode of gratification, and so are driven to seek indirect, symbolic forms of expression. The energy pertaining to them is transformed into these secondary, more permissible kinds of activity, and furnishes a great part of the strivings of mankind that lead to social and cultural interests and development in general. This process of transformation of energy from a repressed, sexual aim to one socially permissible and useful is termed by Freud "sublimation," a figurative expression borrowed from chemistry.

In certain circumstances the attempt to sublimate the primitive impulses is only partially successful. If it entirely fails there remains as a result some form of manifest sexual perversion, the meaning of which had always been a riddle until Freud shewed that they represented merely an exaggeration or distortion of one or other of the infantile components of the sexual instinct. In hysteria the repression does not succeed in leading to the normal sublimation of the primitive impulses into social activities, failing thus to bring about a sufficient renunciation of the old pleasurable tendencies. It is not certain whether this failure is due to an unusual strength of the impulses in question or to an inadequate development of the inhibiting forces; probably both factors are at work. The latter one may plausibly be correlated with the spoiling of children that is so often

followed by hysteria, *i.e.* with the insufficient accustoming of the child to the restrictions that a social life imposes. On the other hand, the repression does not altogether fail. Its influence is still strong enough to prevent the impulses from functioning in their original guise, and forces them to adopt more indirect modes of expression. The compromise between the impulse and the repression leads, as was explained above, to the formation of the actual hysterical symptoms.*

THERAPEUTIC APPLICATION

We have now to take up the bearings of this theory on the subject of therapeutics. The main problem evidently is how to divert into useful channels the misdirected energy that is finding an outlet in the hysterical symptoms. This aim resembles that of the "side-tracking" method, but the way in which it is carried out is fundamentally different in the two cases. In the "side-tracking" method it is hoped that the symptoms will be replaced by social interests if only the opportunity for the latter is offered to the patient, but no serious attempt is made to induce the energy to flow from one channel to the other. It is essential to realise that the symptoms and the social activities that connote recovery from them are both fed from the same source, that the energy manifested in the former has to be actually diverted into the latter. It is plain that the deficiencies of the methods previously described are due to their failure to *release* this energy,

* Sublimation itself is also a compromise-formation, one, however, which differs both qualitatively and quantitatively from that characteristic of neurotic symptoms.

which is locked up in its original and insufficiently altered form. To accomplish this release, and thus set free the energy to be sublimated in the normal way, is the central aim of the psycho-analytic method of treatment.

Freud found by experience that the only really satisfactory way to carry out this aim was by leading into consciousness the repressed, buried wishes that constitute the origin of the pathogenic tendencies, and by thus rendering superfluous the existence of the replacement-formations, *i.e.* the symptoms. Certain definite mental changes follow when this is done. Affects that were previously pent up and localised in a given complex (focus of disaggregation) now become discharged and diffused throughout the patient's mind, thus losing their excessive intensity. Illogical displacements of an affect become resolved through its being traced to its own proper source ; the " inadequate " emotional reactions and inappropriate deportment that were described earlier then disappear. Finally, and most important of all, the repressed complex becomes for the first time directly accessible to the influence of numerous conscious considerations, and can thus be fused and brought into harmony with the rest of the patient's mind. The essential point to grasp here is that consciousness can deal with and control a mental process that is itself conscious far better than one that is not. In every-day life the same thing may be seen, though on a smaller scale because it usually concerns a matter that is only slightly out of the focus of conscious attention, the change brought about being therefore not so striking ; we avoid many irritating little habits and thoughtless pieces of conduct once our attention is drawn to them or

once we realise what before we had not been aware of. All this may be summarised in the sentence that while an unconscious complex is necessarily in a state of dissociation, which means mental disharmony, translation of it into consciousness signifies its assimilation, which means mental harmony.*

Freud, therefore, strictly maintains the therapeutic principle discussed earlier in this chapter, to the effect that fusion and conscious assimilation of dissociated elements is the aim to be striven for. It will by now have been gathered that to carry this out satisfactorily is a much more difficult matter than some writers have supposed, but, being better aware than they of the nature of the obstacles hindering the performance of it, Freud was in a more advantageous position to devise means for overcoming these. He soon realised that intellectual knowledge of the pathogenic complexes on the patient's part was a very different matter indeed from assimilation of them in consciousness, which concerns the emotions much more than the intellect ; one may compare the great difference that exists between enjoying a bowing acquaintance with some one and a prolonged intimacy. As with this analogy, assimilation of a repressed complex in consciousness is a question of degree, with infinite gradations, and to bring about complete assimilation is often a matter of the greatest difficulty. This consideration is not always appreciated by those attempting the practice of psycho-

* On the way in which translation into consciousness alters the unacceptability and state of dissociation of a complex, see my "Papers on Psycho-Analysis," 2nd ed., 1918, pp. 304, 305.

analysis, the difficulty being only too commonly underestimated.

In psycho-analysis assimilation of the pathogenic complexes is not brought about actively, as is attempted by Morton Prince and others, but is allowed to proceed automatically once the obstacles in the way have been overcome. These obstacles consist, as has been remarked, of various "resistances" that are preventing the repressed complexes, and especially the affective part of them, from entering consciousness, and in consequence Freud addresses himself principally to the task of surmounting these resistances. His mode of procedure has undergone very considerable modifications and refinements during its evolution in the course of the past twenty years, and he considers that this evolution is by no means yet complete. Originally he set to work by taking one symptom after another, and attempting to trace the development of it. He soon found, however, that the pathogenic sources of the different symptoms were inextricably inter-related, so that this plan was impracticable, or at least inexpedient. His subsequent method was to pass by the symptoms, leaving altogether the order of exploration to the spontaneous guiding of the patient's mental functioning, thus setting himself the task of sooner or later bringing the whole of the unconscious to light. In doing this he first concentrated his attention on detecting the clues in the material provided that might lead to the complexes themselves, but of late years he has substituted for this plan that of dealing directly with one resistance after another as they present themselves, trusting that the underlying complex will become

manifest as soon as the protecting resistance has been subdued.

The psycho-analytic method makes use of a number of different procedures according to the needs of the moment. The fundamental principle guiding all of them, however, remains the original one of "free association." The patient has to relate freely whatever may come into his mind, however inconsequent, disconnected, or unimportant the successive thoughts may appear to him to be. He has so far as possible to suspend all criticism of such considerations, has to refrain from guiding his thoughts either into any direction or from any direction, and has to confine his attention to the sole task of noticing and relating the thoughts that occur to him. It is found that when the usual guiding of thoughts that takes place in ordinary conversation or thinking is abrogated they become directed by the various unconscious complexes that lie uppermost at the moment. These may not come to direct expression, but they betray themselves by a series of indications, chiefly emotional ones, which the psycho-analyst is trained to observe. The patient may be unable to perceive the significance of the thoughts that occur to him when a buried complex is being neared, being, as it were, blinded to it by the action of the censorship that prevents him from becoming aware of the complex, but to the outside observer this significance is often plain enough. The patient's thoughts keep hovering about the painful spot, they over and over again hint at and thus betray what is at the back of his mind, and from them the observer gets unmistakable clues. It will readily be understood that accumulated experience sharpens the

capacity to interpret the manifestations in question, and to perceive the nature of the painful complex the presence of which is being betrayed. One is in this way enabled to appreciate the kind of resistance that is operative in the patient's mind, to help him to overcome this, and so to allow the buried mental processes to enter consciousness.

During analysis the physician's attitude should form the natural complement to that inculcated in the patient. He also has to suspend his judgement and active thinking, and to adopt a passive, registering, and observing attitude. The interpretation of the material provided by the patient, the hidden connections, between consecutive, but apparently irrelevant remarks, the general appreciation of the significance of all that is observed, are none of them the result of ordinary judgement or active thinking, but ensue automatically and smoothly provided that the workings of the analyst's mind are not impeded by resistances similar to those operative in the case of the patient. From this it is evident that the analyst has himself to undergo a preliminary self-training and analysis of the same kind as that to which he asks his patients to submit. He has to know his own mind thoroughly, to have control of any aberrant or pathological tendencies, and to be master of the resistances against free thinking that are apt to impair smooth mental functioning on emotional or personal topics.

One of the most valuable sources of material for the analysis is furnished by the study of dreams, and it is impossible for any one to carry out a psycho-analysis unless he has by experience made himself familiar with the technique of dream-interpretation. Freud has shewn

that a dream (in both the normal and abnormal) is not the meaningless and insignificant phenomenon it is generally supposed to be, but that it is a complete psychical structure formed according to definite laws and representing the most intimate and important thoughts of the personality. The formation of a dream is extraordinarily similar to that of an hysterical symptom: both are built up by means of the same psychological mechanisms and symbolisms, they constitute a compromise resulting from a conflict between repressed impulses and the endopsychic censorship, they often bear the closest relation to the infantile type of sexuality, they represent the imaginary fulfilment of repressed unconscious wishes, and the actual sources of the two phenomena are frequently identical. As in the case of symptoms, the manifest content, or dream as it is remembered, has to be traced to the latent content, the underlying thoughts that have produced the dream, before its real meaning becomes evident; it is rather like the question of translating from a difficult foreign language. The similarity between dreams and hysterical symptoms, their common origin, and other circumstances that need not be detailed here, make the investigation of dreams the most valuable means we possess for exploring a patient's unconscious mind. Further information on this extensive subject must be obtained from Freud's *Traumdeutung*, which is perhaps his most important contribution to psychoanalysis.

Another fruitful source of material is yielded by the investigation of certain minor failures of mental functioning, of a kind that is commonly to be observed in the normal. Belonging to this group are "accidental" slips

of the tongue and of the pen, inexplicable forgetting of familiar names and commonplace pieces of knowledge, omitting to carry out an intended act, making a mistake and carrying out an unintended act, overlooking matters that would usually be attended to, mis-reading or mis-seeing something, misplacing, mislaying or losing objects, and many other similar occurrences. Psycho-analysis of these trifling failures shews that "chance" plays an inappreciable part in their production, and that they result from the disturbing action of some train of thought that is being kept back. Although they are customarily attributed to fatigue, absent-mindedness, forgetfulness, inattention, and the like, these are only the favouring factors, the agent determining precisely what mistake is made being some dynamic thought that the person does not intend to express, but which takes advantage of the predisposing circumstances. This thought has a definite meaning, and there is a motive in the mistake made, *i.e.* the latter is, like an hysterical symptom, a disguised wish-fulfilment. There are occasions on which even common intuition divines the true state of affairs. Thus, if a lady, on embracing some one by the name of William, were to make a slip and say, "I love you so much, Harold," some curiosity might not unnaturally be displayed as to the identity of Harold. Much valuable information may be gained by attentively observing and examining this group of occurrences, for they betray thoughts, usually of significance, that the patient wished to conceal. In many cases the analysis, which brings to light highly important tendencies that the patient may not have been at all aware of. Freud has devoted to this subject a book entitled

Die Psychopathologie des Alltagslebens, in which further details may be found.*

An adjunct to psycho-analysis that is useful for beginners is the word-association method as adapted by Bleuler and Jung. A number of simple words are called out to the patient, who has at once to answer to each with the first word that comes to his mind ; the interval between the stimulus and the reaction ("reaction-time ") is measured by means of an ordinary stop-watch. It is found that with various words, which cannot of course be predicted beforehand, the patient is unable to respond smoothly and easily ; he stumbles, and the response shows certain peculiarities termed by Jung "complex-signs." There are over a dozen of these, the chief being : delay in the reaction-time (corresponding with the falter of an embarrassment), inability to respond at all within a given time (temporary mental confusion, an exaggeration of the last), an anomalous superficial association—especially when it occurs repeatedly with similar test-words—repetition of the stimulus-word (akin to the stammering echo with which a person may respond on being taken aback by an awkward question), repeated use of the same word throughout the examination, assimilation of the stimulus-word in an unusual or unexpected sense, perseveration in subsequent reactions, and erroneous or defective reproduction of the reaction-word when the patient is asked later to recall the answers he gave to the individual stimulus-words. The stimulus-words that evoke several of these peculiarities in the reaction are always words

* Or in the author's "Papers on Psycho-Analysis," 2nd Edit., 1918.

that are connected with some significant emotional complex, so that they serve as clues to the discovery of these. The method is chiefly of use in giving one a general preliminary orientation as to the emotional factors in the patient's mind, and for this purpose it is by some workers employed as a first step in the analytic treatment. For further details the reader is referred to Jung's *Diagnostische Assoziationsstudien*.

The presence of emotion when a complex has been stimulated by one of the stimulus-words in the association test can be objectively verified, and graphically registered, by observing certain physiological manifestations that accompany it, for instance, respiratory and circulatory changes. Through the work of Jung, Binswanger, and others a particularly delicate method for this purpose has been elaborated, known as the "psycho-galvanic reflex." It is based on the discovery made for the first time in 1888 by Féré that in the presence of emotion the body offers a greater resistance than at other times to the passage through it of a galvanic current; the increase in the electrical resistance is perhaps due to the dampening of the surface of the body by an imperceptible increase in the secretion of the sweat glands. The method is much too cumbrous for therapeutic purposes, but it is of interest as confirming the theory of the word-association method, since it provides a sensitive and objective check on the inferences drawn from the occurrence of complex-signs. In this connection it may also be mentioned that the familiar observation of a quickening of the pulse in the presence of emotion has been re-discovered by Coriat under the somewhat grandiloquent title of the "psycho-cardiac

reflex''; he uses it in conjunction with the association method.

As was indicated above, the material gained in these various ways is then submitted to a process of elaboration and elucidation, whereby the same characteristics in different parts are brought together, correlations established, obscurities clarified, and underlying connections and meanings made plain. The resulting interpretations are made use of to direct the patient's attention towards the more hidden material for which they furnish clues. The technique of psycho-analysis comprises innumerable minor rules dealing with the interpreting of material, and with the difficult question of how to decide the right moment for conveying the interpretations to the patient.

We have, finally, to discuss the question of how one deals in psycho-analysis with the affective *rapprochement* between patient and physician that was seen above to constitute the essential basis of suggestion. It was pointed out that this *rapprochement*, which is inevitable in any relationship between patient and physician, is brought about by the former transferring to the latter various positive affects of sympathy, liking, attraction, etc., which were previously present in his mind, and which originated in connection with persons having considerable significance to him; further, that the occurrence is only one form of this displacement, another being that of various negative affects, of antipathy, dislike, etc. In the simpler methods of treatment the physician is to a great extent at the patient's mercy so far as this transference is concerned. If it is of a negative kind, then called a "resistance," the treatment fails; if it is of a positive one, the patient may improve,

but is then very liable to become unduly attached to and sustained by the physician, thus being not able to deal independently with the exigencies of reality. In psycho-analysis, on the contrary, the physician does not stand helplessly before the situation, but takes advantage of it for therapeutic purposes. Every time he finds himself the object of transference of some affect—and there are special means for observing the earliest indications of this—he institutes an analysis and traces the origin of the reaction in question. In this way he is able to guide the source of it into the patient's consciousness, and, by making him aware of his previously unconscious tendencies, to put him in a position to control, divert, or otherwise modify them. It should be said, however, that the management of these transferences constitutes the most difficult part of any psycho-analysis, and one, therefore, to which the beginner would do well to pay special attention. One reason for this is that, in ways that cannot here be gone into, the process is the chief one employed by the patient's unconscious to manifest its resistances against the aims of the treatment. Suggestion is thus the main hindrance to treatment by psycho-analysis, and this is one of the grounds, amongst others, why the psycho-analytic method cannot be combined with treatment by means of suggestion or hypnotism, as Forel and others have unthinkingly advocated; the two systems are fundamentally opposed in their aims. The recognition of the meaning of the positive and negative transferences, with the handling of them based on this knowledge, constitutes the most distinctive mark of psycho-analytic, as opposed to any form of non-analytic treatment. It is only *via* these transferences that the

analysis can proceed, beyond at least the earliest stages ; it is only by making the old buried motives and emotions current and actual in the transference situation that one can lead the patient to a complete realisation and assimilation of them.

Anagogic Analysis.—This method of conducting a psychological analysis, which was devised first by Adler, and then, more or less independently, by Jung, Maeder, and Silberer, has perhaps more reference to pathology than to therapeutics, but as it has an important bearing on practice as well as on theory something must be said about it here. It will be remembered that the psycho-analysis of neurotic symptoms led to their being regarded as the derivatives and substitutes of various unconscious strivings of a kind that had proved incompatible with the ideals of consciousness ; they were traced ultimately to various infantile complexes. At first these findings were simply denied by those who found them unpalatable, but when this mode of defence began to break down under the sheer weight of the evidence brought forward it became necessary to devise a less rudimentary one, and it was discovered that it was possible to deprive the findings of their obnoxious qualities in the following way. It was observed that another set of mental traits, socially useful and fully acceptable to the conscious ideal, were also derived in great part from the same infantile complexes as the neurotic symptoms and thus stood in a certain associative relation to the latter ; no one who has investigated the matter has failed to see that these three sets of mental processes—the infantile complexes, the neurotic symptoms, and the sublimations—are intimately connected with one another. In fact, it is

customary to find that the patient's free associations lead from the symptoms to the sublimations as well as to the infantile complexes. Instead, now of viewing the matter genetically, as psycho-analysts do, the attempt was made to reverse the state of affairs and to regard the symptoms purely as substitutes for the sublimations, in the sense that the energy animating them was derived from fully formed sublimations which for some reason had never been able to express themselves directly. The inopportune fact that the patient's associations also led to the memory of infantile complexes was dealt with by regarding these also as unfortunate substitutes for the same sublimations. In the face of all the teachings of biology and comparative anthropology the comfortable view could then be propounded that the primary and most fundamental tendencies of the mind are of a highly ethical or religious nature, of which neurotic symptoms and the infantile complexes associated with them are merely secondary symbols. In this way Adler came to regard the sexual complexes in question as merely symbols of the striving for power and success in life, a conception which Jung replaced by a purely ethical one. Both succeeded in relegating Freud's conception of infantile sexuality to the oblivion from which he had rescued it, and in leaving the study of the unconscious for the more familiar one of conscious and preconscious ideals.

The influence of these views on practice was not long in manifesting itself. In place of establishing a more harmonious fusion between the trends of the unconscious and those of consciousness, the tendency became more and more pronounced to depreciate or ignore any indications of the unconscious—falling in thus with the patient's

own preferences—and to explain to him that his symptoms were only badly-chosen symbols for various cultural strivings. By this means the whole work of psycho-analysis in overcoming the resistances that separate the different regions of the mind was obviated, and a return made to Putnam's side-tracking or Dubois' persuasion methods, involving the imperfections and disadvantages that were discussed above in connection with these. It is for this reason that the anagogic methods have been classed here as members of the re-education group.

GENERAL CRITICISM OF THE PSYCHO-ANALYTIC TREATMENT

The advantages of this method will be considered in reviewing the general subject of mental therapeutics, and we shall confine ourselves here to its disadvantages, real and assumed. Although I am personally an advocate of psycho-analysis, I freely recognise that the use of it in practice presents many difficulties and drawbacks, but I am also alive to the circumstance that the evident truth of there necessarily being limits to the applicability of the method has been extensively exploited by those who are really opposed to it on other grounds.

It is not easy to define the limits of a method that is still in the process of evolution. The improvements in technique introduced since the method was first devised have extended its field of operation beyond what was then thought possible, but they have on the other hand more sharply defined its limitations in other directions, most of which are now known in considerable detail. For instance, obviously nothing can be done with patients who are brought more or less against their will to be treated,

this applying also to all other modes of treatment. A certain level of intelligence is necessary, but hysterical patients are not often grossly deficient in this respect ; in my own experience, which includes a considerable number of cases among the uneducated classes, a lack of sufficient intelligence has only once or twice proved a bar to the treatment, and even in these there were other important factors acting in the same direction. It is not easy to treat a patient if one is not thoroughly familiar with his mother-tongue, for in these circumstances it is hard to follow the play on words and the references to the idioms of childhood. Age is a serious obstacle, as it is also with other methods. The reason for this is not so much the diminished plasticity of the mind, a feature which varies very greatly with different people, or even the extent of material to be worked over—the symptoms becoming increasingly over-determined as time goes on—as the lessened opportunity for re-adjustment in life, for making a fresh start ; this last-named factor is also important in affecting the physician's interest in the case, for the task of re-adjusting a personality is necessarily more attractive and hopeful with some one who has the most of life still before him. Freud sets the age of fifty as the upper limit, but several workers, including myself, have had considerable success with patients older than this, even up to sixty. It is further desirable that the patient's personality should possess a certain moral value and earnestness, for in such cases one can achieve much better results. In deciding whether a given patient is suitable for the treatment one has thus to bear in mind a number of considerations ; in spite of the qualifications just mentioned, however, the

method is certainly applicable in the majority of cases of hysteria.

From the patient's point of view the disadvantages are mainly two. Instead of being "spoon-fed" with some comfortable treatment that makes him well while he passively awaits the results, and which makes no special call upon his mental activities, he is here called upon to participate vigorously in efforts against which a great part of him is constantly rebelling, and which may severely tax his powers of determination and patience. In practice, however, it is found that the new self-knowledge gained during the progress of the investigation, together with the insight into the meaning of the resistances, goes far to counterbalance the tendency to resign without a struggle, and that with a tactful physician it is rare for a patient who truly desires to get better to give up on these grounds. The other disadvantage is the amount of time consumed. This is always a question of many months at least, and in many cases it may be a year or even much longer. Much thought and effort have been expended on the possibility of reducing the time taken, but hitherto without avail; indeed, increased experience seems only to have the effect of pointing to the necessity for a more thorough, and therefore longer, treatment than used to be attempted. Unfortunately the slowness with which revolutionary changes in the mind can accomplish themselves imposes an inevitable check on all efforts seriously to diminish the duration of treatment, so that the time necessary remains as an unmistakable disadvantage in the psycho-analytic method. Against it, however, have to be put the following considerations: Many cases are otherwise incurable,

or amenable only to inappreciable alleviation ; provided that other circumstances allow, psycho-analysis can be carried out while the patient is engaged at his vocation, this indeed being an important desideratum from the point of view of the treatment alone ; finally, the time demanded for a radical form of treatment that promises permanent freedom from suffering, with heightened general capacity, does not seem excessive when it is compared with the total amount of time expended by such patients in sanatoriums and rest homes, or on health voyages and recreative holidays. Similar considerations apply to the matter of cost, which may be even more than that of a major surgical operation ; in this respect the drawback of time applies to the physician rather than to the patient, for the relation of fees to the time spent is always less than in any other form of specialist work.

A great number of other objections have been raised to both the psycho-analytic method of treatment and to Freud's theory of hysteria on which it is based. Nothing will be said here about the latter except that they are neither more nor less cogent than the others. Many of the hostile criticisms have been made to serve a polemical rather than a scientific purpose, and these it would be more charitable to ignore. It can readily be demonstrated that many of the individual objections are merely pretexts seized at in order to cover deeper ones, and often those who bring them forward are themselves unaware of the unconscious roots of their antipathy. The method runs counter to two of the most formidable of prejudices. In the first place, the play on words by means of which much of the analysis is performed instinctively offends the normal

conscious mind and produces a feeling that the connections established are strained and far-fetched ; this is inevitably so unless one bears in mind that the mental processes concerned behave in this illogical fashion, which inherently differs from that characteristic of conscious modes of thought. The unravelling of a symptom proceeds along the same paths that were traversed in the spontaneous making of it, and therefore necessarily reveals mental mechanisms foreign to the conscious mind, but distinctive of the unconscious. The individual details of the connections and symbolisms disclosed by the free association method have been amply confirmed by comparison with those occurring in other products of the human phantasy, notably in wit, slang, folk-lore, superstitions, certain religious beliefs, philological processes, and, most strikingly of all, by the spontaneous interpretations yielded by the insane, while the theoretical principles of the method rest not only on empirical findings and results, but also on the objective proofs established by the early experimental work of Jung and other workers. The other prejudice referred to concerns the subject of sexuality, and it will be acknowledged that there is no other subject that has been submitted to such powerful taboos as this has.

Psycho-analysis thus uncovers a type of thought, the symbolising or phantastic one, and a group of mental processes, those relating to sex, and especially to the infantile form of sexuality, against the manifestation of which potent forces are operative in the mind of the normal as well as in that of the hysteric. These forces, the same ones that with the hysteric produce the distortion in the expression of the buried wishes, and the resistances

encountered during treatment, lead in the normal to the employment of every pretext and argument that may avail to discredit any measure intended to reveal them. These arguments owe much of their strength and appearance of justification not to their intrinsic merits so much as to the unconscious factors of which they are really the symbols. Intellectual processes that are merely representative of deeper emotions are extremely hard to modify without dealing with the underlying forces, for, as anyone may discover by attempting to reason with a patient suffering from an obsession or delusion, the power of mere logic in this respect has very definite limits. Stress has been laid here on these general considerations, since experience has shown that endless effort may be wasted in vainly refuting individual arguments, and that the only way of fairly passing judgement on the problems at issue is by first dealing with the nature and causes of prejudices that tend to blind the observer and distort his judgement.

Perhaps the commonest objection urged against the psycho-analytic method is that it is harmful to investigate a patient's sexual thoughts. This is usually accompanied by a denial of the importance of such matters in regard to the pathogenesis of hysteria, an argument well designed to buttress the objection in question; the procedure is rather similar to that of anti-vivisectors who believe experiments on animals to be wicked, and support this by saying that they are also useless and misleading. Granted, however, that the psycho-analytical view of the pathogenesis is correct—and this is a matter on which those best qualified to judge have no longer any doubt—then those

who sustain the objection just mentioned are in the curious position of holding that a group of agents of considerable pathogenic importance are to be isolated from all others and to be regarded as not belonging to the sphere of medical science, a position on a level with the old view, still adhered to in Eastern harems, that only a strictly limited portion of the human body should be accessible to medical examination. The precise harm that it is feared might possibly accrue from psycho-analytic investigation is rarely if ever defined, so that it is hard to discuss the matter in any detail. It may, however, be freely granted that some potentiality for harm does really exist in the exploration of sexual thoughts and fancies, just as there exists a distinct potentiality for harm in the exploration of the various cavities of the body, but it is obvious that in both cases the harmfulness of the procedure greatly depends on the way in which it is carried out ; a systematic investigation of the mind performed by a trained psycho-analyst differs from a vague "talking about sexual matters" quite as much as an aseptic laparotomy differs from the rending thrust of a cart-shaft. In this connection it may not be out of place to remark that of late, since the therapeutic successes of psycho-analysis have become more recognised, some physicians have undertaken to carry out the treatment without properly informing themselves of the difficulties involved, and without undergoing the necessary preliminary training ; in such circumstances, of course, no guarantee can be given that no harm will be done in the name of psycho-analysis.

The question is sometimes asked why the buried sexual thoughts, assuming they exist, should not be left to lie

in peace. The answer to this is simple: everyone would be content to leave them so, but the trouble in hysteria is that they are not at peace, and do not allow the patient to be. The effect of psycho-analysis is to substitute harmonious peace for the turmoil of hidden conflict.

The fear is often expressed that the exploration, which is so integral a part of this treatment, may increase the tendency to morbid introspection already pronounced enough with these patients. On the contrary, psycho-analysis strikingly frees them from this tendency. The morbid introspection is due to their not being able to get away from the influence of the disturbing unconscious complexes, while after this influence has been modified the patient is for the first time able to dispense with the necessity for the ceaseless and vain self-examination, and can devote his attention and energies to useful activities. Beyond the fact that both may be termed forms of introspection there is nothing in common between the egocentric broodings of the neurotic, ever revolving in the same circle, and the progressive exploration of psycho-analysis, with the steadily expanding self-knowledge and insight that accompany its advance.

Another prominent objection is to the effect that the practice of interpreting the patient's associations introduces an incalculable personal factor, and hence an undue subjectivity in the procedure. It is, of course, true that this practice, being a psychological process, does introduce a personal, subjective factor, just as the interpretation of the various cardiac sounds heard with a stethoscope, or of the sensations experienced on palpating an

abdominal tumour, also necessarily involves the introduction of this factor. Subjectivity can be minimised in any mental operation, such as that of judgement, only by rigid adherence to the rules of scientific thinking, which apply as strictly to psychological as to physiological modes of investigation, and by careful study of the subjective difficulties that disturb this process. The justifiability of any given inference that may be drawn from observations made, and of any generalisation, depends exclusively on two criteria, namely, on the capacity of the generalisation to resume—or “explain”—all the observable phenomena, and to predict the occurrence of future similar phenomena. In psycho-analysis the criteria of science are adhered to as strictly as in any other branch of scientific medicine. It presents, further, the unique safeguard that the person carrying out the investigation is, through self-analysis, well aware of the psychological inhibitions that are apt to interfere with the application of the rules of scientific thinking. The subject is inherently too complicated to permit, at all events as yet, of inclusive laws being formulated in regard to every detail, in the way that they can with the chemical analysis of a simple salt, and of thus making the procedure largely independent of personal experience and judgment; but nevertheless the opportunities for the confirmation and verification of the individual inferences are both numerous and satisfactory enough to check any fluctuations introduced by the “personal equation,” and to lend to those made by an experienced psycho-analyst a very high level of probability. Further discussion of this matter would lead us too far into the subject of the detailed technique of psycho-

analysis, for the study of which the reader must be referred to the special works on the subject.

V. CONCLUDING REMARKS ON MENTAL THERAPEUTICS

In comparing the different forms of mental therapeutics, just as in the case of any other clinical procedure, it is desirable to keep distinct the questions of their scientific value and of their clinical applicability in view of the exigencies of practice; the former will be considered first.

The comparison of the therapeutic results obtained by means of the various forms of treatment described above is far from easy, partly because the criteria of recovery are less clearly defined in hysteria than they are in most diseases, and partly because of the difficulty of securing an adequate number of cases that have been treated in different ways and the subsequent history of which has been followed up for the length of time necessary to form a judgement. In these circumstances there are only two ways of reaching a comparative estimate: first by studying the effects of different modes of treatment on the same cases, and secondly by weighing the impressions formed by the experience of those who have made use of more than one method. Unfortunately, however, the number of workers who have this comparative experience at their disposal is very small, since most men, for sufficiently evident reasons, confine themselves to one system of treatment. The opinions of those who have worked only with the simpler methods are necessarily of little value in the present connection; on the other hand,

although most of those who practise psycho-analysis were previously accustomed to use hypnotism, hardly any of them have a thorough knowledge of the re-education methods of Janet, Prince, Vogt, and others. Personally I have had a fairly extensive experience of all the main methods here described, and therefore venture to found my conclusions largely on the basis of this experience. They are as follows : In the first place, I have had gratifying successes with every one of the methods in question, but also failures with all of them. An immediate inference that seems to follow from this is that it is quite easy to bring about recovery in a practical sense with some cases, and very difficult, or perhaps impossible, with others ; most cases probably lie between these extremes. The quality of the success attained by the various methods, however, has shewn striking differences, improving unmistakably with the increasing thoroughness of the procedure adopted as presented in the graduated series described above. A similar conclusion is forced on one by comparison of the results obtained by treatment of the same case by different methods. I have heard of only one case in which another method, the hypnotic one, succeeded better than the psycho-analytic, but I have personally observed a great many in which this succeeded after other methods had failed ; indeed, it is rare for a patient to come to me for psycho-analysis without his having been already treated in vain by one or more other methods. Except under the rarest circumstances I have quite discarded the use of methods involving suggestion, because of the incompleteness of the results as compared with what can be obtained in other ways, the disadvantages

of creating a condition of dependence, and the utter impossibility of predicting with any degree of certainty the future evolution of the disease after apparent recovery has been brought about. According to my experience the psycho-analytic method escapes these defects to a much greater extent than any other. Dealing as it does far more radically with the fundamental causes of the malady than any other method, and fulfilling better than any other the "activity" criterion discussed above, it is concerned not only with the roots of the current symptoms, but with the whole pathogenic material in the patient's mind, and thus affords the surest prophylaxis against any later morbid developments. In some respects, indeed, psycho-analysis may be regarded as signifying far more than a mere therapeutic measure, namely, a thorough re-education of the patient's whole mind, with a corresponding gain in self-knowledge, self-guidance, and self-control.

The present writer is thus convinced of the surpassing value of the psycho-analytic method in the treatment of hysteria, and would advocate the use of it whenever this is possible. It remains to be discussed, however, to what extent this is feasible in the present state of medical practice. It has, for instance, been urged that the use of the method will have to be confined to a few specialists, on the ground that to acquire the technique of it demands a special course of study, including almost of necessity a preliminary self-analysis. Some writers have even expressed the opinion that it can be acquired only by those having special gifts of psychological insight. This latter point can certainly be contradicted: there is every reason to believe that the number of physicians who have not the

capacity to make successful use of the method is decidedly small, although it is to be expected, as in the case of any other difficult technique, *e.g.* bacteriological or surgical, that those possessing certain qualities will attain to a higher standard of excellence than others. Even if the use of the method were to be confined to a few, as the performance of various specially delicate surgical operations practically is, it is hardly a tenable position to maintain that the general physician is not called upon to know anything about it. An important further consideration to be borne in mind here is that a knowledge of at least the principles of the subject is highly desirable for general practitioners, who of necessity come most into contact with such patients, since a very great deal can be done to prevent a later hysteria by paying attention to relatively simple matters in early childhood provided that one knows which of these are of the most essential importance.

That the medical profession as a whole is so unprepared to undertake the carrying out of psychological measures is a highly undesirable state of affairs, especially in view of the recent encroachments in this respect on the part of unqualified persons, and it is one not to be remedied by the creation of a small class of psychological consultants. It is on all sides becoming increasingly plain, and more especially since the War, that the perpetuation of the present apathy towards the subject of mental factors in disease is equally harmful for the prestige of the profession and the health of their patients. The reluctance, or inability, of so many physicians to take up the use of adequate measures for the treatment of

hysteria is only one more argument in support of the conclusion, now widely recognised, that medical education urgently needs to be supplemented by the introduction of systematic training in the principles of clinical psychology, a subject that is at present almost ignored in the curriculum.* The difficulty in presenting a method such as psycho-analysis is thus a reflection on medical education rather than on the nature of the method. For some time to come no doubt physicians will continue to use the cruder and less adequate modes of treatment, but it will be with a steadily growing realisation that they are not doing for their patients what can be done, and that valuable progress in knowledge has been made of which the deficiencies in their education prevent them from taking due advantage. These considerations gain force when it is remembered that they apply not to the treatment of hysteria alone, nor even to that of the neuroses in general, but to a much wider range of morbid conditions than is commonly imagined.

E. W. Taylor has entered a plea for a modified form of psycho-analysis, his view being that since the method had proved so valuable it should be simplified so as to bring it within the reach of those untrained in clinical psychology. It does not seem, however, even remotely probable that the attainment of this desideratum is in any way practicable, for advancing knowledge of the subject has only made more evident the complexity of the factors involved, necessitating a corresponding elaboration in the technique of the method. The complexity lies not in the method but

* See in this connection the excellent volume by Elliot Smith and Pear, "Shell Shock," 1917.

in the material, and the difficulties in the way of simplification, therefore, are inherent, not accessory. The illustrative examples brought forward by Taylor * are not at all to the point, for they are not examples of any kind of psycho-analysis, but of the simplest forms of "explanation"; they suffer in consequence from the disadvantages remarked on above in the discussion of this topic. Taylor's proposition would have been more valuable if he had directed attention to the fact that simple advice on the part of a physician versed in the principles of psycho-analysis is often of the greatest practical benefit to a patient, apart from any question of treatment, and may save him from much later suffering; this, indeed, was what was intended above in urging on the medical profession in general the importance of a knowledge of the subject. It would be a serious error, however, to confound this giving of practical advice, the necessary limitations of which have been previously discussed, with psycho-analysis itself.

It has further been said that the time involved in psycho-analytic treatment precludes at any rate the application of it to hospital and dispensary patients. It is evident, however, that this is entirely a matter of will, not of means. If it is considered desirable to do the best for such patients a way will be found, though it would certainly necessitate the training of a larger number of psycho-analysts than are now available. One has only to recall the history of the development of the sanatorium treatment for tuberculosis. A prominent criticism of this

* E. W. Taylor, "Journal of Abnormal Psychology," vol. iv. p. 449.

treatment in its early days was that it could be applied only in the case of wealthy patients, but as soon as it was realised that without it the best was not being done for the patients, the material difficulties were overcome, special buildings were erected, physicians and nurses trained along suitable lines, and a system of treatment instituted that has not many parallels in the expense and complexity of organisation involved. For psycho-analysis, on the contrary, all that is needed is physicians ; and in ability to alleviate suffering and promote general social efficiency the psycho-analytic method will bear favourable comparison with any treatment of tuberculosis.

Finally, it is not only desirable, but indispensable, that something should be said here on another matter, namely, the relation of the clergy to the medical profession. As is well known, clerical pretensions in regard to the treatment of mental disorders, principally the neuroses, have been revived of late in a rather prominent way. I refer not only to the cruder and not generally admitted claims of such bodies as those engaged in the Emmanuel movement and Eddyism, but to efforts made among more responsible circles, of which the following instance may be quoted : A special committee, representative of the clerical and medical professions, and having as its Chairman the Dean of Westminster, was formed in 1910, and, after holding a number of sessions, has issued two interim reports of the conclusions reached (1912 and 1914). One of the chief of these is that the ministrations of the clergy may be of most direct therapeutic assistance with nervous or mental patients, provided, of course, that these are open to religious influences. One report goes on to

say : * “ The medical practitioner should realize that . . . in certain cases patients can be approached from the spiritual side when ordinary methods of medical suggestion are more difficult to apply. Such cases are more often of the nature of functional disorders, minor obsessions, or vicious habits.” The statement seems to represent a very general medical opinion, and is without doubt an honest expression of what are pessimistically felt to be the limits of therapeutic possibilities, and an acknowledgment of the bankruptcy of “ the ordinary methods of medical suggestion.” To remedy this state of affairs by the more scientific proceeding of dealing with the deficiencies in medical education discussed above does not seem, as far as one can gather, to have occurred to the committee. Now this is not the place to attempt to appraise the value of clerical encouragement in the case of disease in general, nor is this a matter about which there is much difference of opinion, but it must be protested that it is no longer necessary to have recourse to another profession to aid us in performing what is strictly our own duty, namely, the treatment of mental disorders ; the church has occupied this field for thousands of years, but the day has now come when exorcism and prayer must yield the place to scientific therapeutic measures, here as in the treatment of organic disease.

It is very rarely desirable that the task of correcting and modifying morbid mental processes should be shared by a physician and a clergyman, for it is peculiarly necessary in this field that the patient should be led by a single hand, with undivided authority and consistently harmonious

* *Brit. Med. Journ.*, March 23, 1912.

aim. The attitude of a psychologist and a clergyman must inevitably differ in many, often important, respects, both because the one is versed in the subject in question while the other is not, and because the two start from quite different premises. It is true that a few clergymen, notably the Rev. Pfister of Zurich, have undergone an adequate training in clinical psychology, and have accomplished excellent results in the scientific correction of aberrant mental tendencies. They are, however, exceptions, and it is to be hoped that they will remain so, for it is a questionable precedent to equip men, however satisfactorily, for the treatment of some morbid conditions and not for that of others. Properly to estimate the significance of intercurrent physiological happenings, even granted that a preliminary diagnosis of hysteria has been correctly made for the clergyman by a physician, is possible only for some one who has completed a general medical training. As the matter stands at present most physicians are trained on the physiological side only, and not on the psychological, while most clergymen are not trained on either side. If mental disorders are to enter into the province of the physician as definitely as physical ones have, and if encroachments from without are to be successfully resisted, it is certain that medical education will have to be extensively widened so as to include an adequate training in clinical psychology.

BIBLIOGRAPHY

GENERAL

- Bleuler. "Psychotherapie," *Munch. Med. Woch.*, 1905, s. 222.
- Freud. "Ueber Psychotherapie," *Wiener Med. Presse*, 1905, Nr. 1.
(Reprinted in his "Sammlung," etc.)
- Hart, Bernard. "The Methods of Psychotherapy," *Proceedings of the Royal Society of Medicine*, Dec., 1918.
- Loewenfeld. "Lehrbuch der gesammten Psychotherapie." 1897.
- Münsterberg. "Psychotherapy." 1909.
- "Psychotherapeutics." A Symposium by Various Authors. (Badger, Boston.) 1909.
- Prince, Morton. "The Psychological Principles and Field of Psychotherapy," *Journ. of Abnormal Psychology*, vol. iv.
- Raymond. "Névroses et Psycho-Névroses." 1907.
- Rosenbach. "Nervöse Zustände und ihre psychische Behandlung." 1897.
- Sollier. Numerous articles in the *Archives de Neurologie* and the *Journal de Psychol.*
- See also the *Journal of Abnormal Psychology*, *Journal de Psychologie*, *Zeitschrift f. Psychotherapie u. medizinische Psychologie*, and *Journal f. Psychologie u. Neurologie*.

SUGGESTION AND PERSUASION

- Babinski and Froment. "Hysteria or Pithiatism" (Engl. Transl.). 1918.
- Benedikt. "Hypnotismus und Suggestion." 1894.
- Bérillon. Numerous articles in the *Revue de l'hypnotisme*.
- Bernheim. "Hypnotisme, Suggestion et Psychothérapie." 1903.
- Bramwell, Milne. "Hypnotism: its History, Practice, and Theory." 1906.
- Camus et Pagniez. "Isolement et Psychothérapie." 1904.
- Déjerine et Gauckler. "Les Manifestations fonctionnelles des Psychonévroses: leur Traitement par la Psychothérapie." 1911.
- Dubois. "Les Psycho-Névroses et leur Traitement moral." 1908.
- "L'Education de soi-meme." 1908.
- Ferenczi. "Introjektion und Uebertragung," *Jahrbuch der Psychoanalyse*, Bd. i. (Reprinted in his "Contributions to Psycho-Analysis." 1916.)
- Forel. "Der Hypnotismus oder die Suggestion und die Psychotherapie." 1911.
- "Hypnotism." Discussion at the International Congress for Medical Psychology, *Journ. f. Psychol. u. Neurol.*, Bd. xix.
- Jones, Ernest. "The Action of Suggestion in Psychotherapy,"

Journ. of Abnormal Psychology, vol. v. (Reprinted in "Papers on Psycho-Analysis." 1918.)

Lévy. "L'Éducation rationnelle de la volonté ; son emploi thérapeutique." 1907. "Neurasthénie et Névroses : leur guérison en cure libre." 1909.

Putnam. "On the Etiology and Treatment of the Psychoneuroses," *Boston Med. and Surg. Journ.*, 1910.

De la Tourette. "L'Hypnotisme et les états analogues." 1889.

Tuckey, Lloyd. "Treatment by Hypnotism and Suggestion." 1913.

See also the *Revue de l'hypnotisme* and *Zeitschrift f. Hypnotismus*.

RE-EDUCATION

Bezzola. "Zum Analyse psychotraumatischer Symptome," *Journ. f. Psychol. u. Neurol.*, Bd. viii.

Contet. "Les méthodes de Rééducation en Thérapeutique." 1905.

Janet. "Traitement psychologique de l'hystérie" in Robin's "Traité de thérapeutique," 1988 ; "Les médications psychologiques," 1919 *et seq.*

Jones, Ernest. "The Mechanism of a severe Briquet Attack," *Journ. of Abnormal Psychology*, vol. ii. "Remarks on a Case of Complete Autopsychoic Amnesia," *Journ. of Abnormal Psychology*, vol. iv.

Jung. "Analytical Psychology," 2nd Ed., 1917.

Prince, Morton. Numerous articles in the *Journal of Abnormal Psychology*.

Vogt, Oskar. Numerous articles in the *Zeitschrift f. Hypnotismus*, especially Bde. iii., xi.

PSYCHO-ANALYSIS

Brill. "Psychoanalysis : Its Theory and Practical Application," 2nd Ed., 1914.

Breuer und Freud. "Studien über Hysterie," 1895. (Part of this has been translated under the title "Selected Papers on Hysteria and other Psychoneuroses." 1909.)

Ferenczi. "Contributions to Psycho-Analysis" (Engl. Transl.), 1916.

Freud. "Sammlung kleiner Schriften zur Neurosenlehre," four volumes, 1906-1910. "Vorlesungen zur Einführung in die Psychoanalyse," three volumes, 1915-1917.

Hitschmann. "Freud's Theory of the Neuroses" (Engl. Transl.), 2nd Ed., 1917.

Jones, Ernest. "Papers on Psycho-Analysis," 2nd Ed., 1918.

Jung. "Psychoanalyse und Assoziationsexperiment," *Journ. f. Psychol. u. Neurol.*, Bd. vii. "The Association Method," *American Journal of Psychology*, 1910.

Kaplan. "Grundzüge der Psychoanalyse." 1914.

Muthmann. "Zur Psychologie neurotischer Symptome." 1907.

Pfister. "The Psychoanalytic Method" (Engl. Transl.). 1917.

Putnam. Numerous articles in the *Boston Med. and Surg. Journ.*,
Journ. of Nerv. and Ment. Dis., etc.

Régis et Hesnard. "La Psychoanalyse des Névroses et des Psychoses." 1914.

See also the *Zentralblatt f. Psychoanalyse*, *Jahrbuch der Psychoanalyse*, *Internat. Zeitschr. f. ärztl. Psychoanalyse*, *Psychoanalytic Review*, and the forthcoming *International Journal of Psycho-Analysis*.

CHAPTER III

ANXIETY NEUROSIS

THE symptoms grouped under this title are usually included in the text-books under that of neurasthenia, an unfortunate error, for it obscures the important fact that the pathology of the two conditions is widely different. The group of anxiety symptoms was first clearly described by Hecker, in 1893, and was independently separated from neurasthenia proper by Freud, in 1895, and Morton Prince, in 1898 ; both the symptomatology and pathology of the condition, however, were very inadequately dealt with by the last-named author.

The name "anxiety neurosis" (*Angstneurose*) was applied by Freud to the condition because morbid anxiousness is the symptom most constantly present, and because all the other symptoms stand in the closest relation to this and may be regarded as merely manifestations of it. Prince used the term "fear neurosis," which, however, does not so well indicate the distinction between normal fear and morbid anxiety (*Angst*).

A. SYMPTOMS

The symptoms may be divided into paroxysmal and inter-paroxysmal, though the former are often only exacerbations of the latter. In an acute attack the dread is sometimes very intense, and is often accompanied by a

feeling of congestion in the head, with a fear of impending apoplexy, insanity, or death; consciousness may even be lost, many cases of fainting being really examples of this condition. The thought processes are either hurried and agitated or they may be inhibited so that the mind "becomes a blank." In mild attacks the patient experiences only a sense of embarrassment or confusion, and is unable to collect his thoughts; common occasions are just before undergoing an oral examination, delivering a speech, or appearing on the stage ("stage-fright"). There is an increase in the rate of the heart's action, sometimes with anginal pain, marked palpitation, fluttering and irregularity and it may seem temporarily to stop; many cases of the so-called soldier's irritable heart, nowadays labelled "disordered action of heart," are really of this nature. General tremor and sweating occur, and the pupils are widely dilated. Nausea, and sometimes vomiting, may be present; excessive and irregular contraction of the involuntary muscle fibres takes place, which may result in a peristaltic diarrhœa, strangury, tenesmus, seminal or vaginal emissions, vaso-motor constriction with coldness and blueness of the skin, and so on. The bodily secretions are profoundly affected, cessation of the salivary and gastric flow, with increased pouring out of urine and sweat, being the rule. Respiratory symptoms are in some cases very pronounced, the chief being asthmatical attacks with air hunger and feelings of oppression and suffocation.

Very often the attacks are larval or incomplete, *i.e.* only some of the symptoms appear. The commonest of these are attacks of palpitation, vertigo, sudden hunger,

sweating, an imperative desire to micturate or defæcate, and suffocative feelings. They are accompanied by a variable amount of anxiety, though the patient, having his attention concentrated on the physical disturbance, may not spontaneously complain of this.

In the chronic condition there is an apprehensive expectation, which readily becomes attached to one idea after another that can in any way justify anxiety ; such are the ideas of poverty or bankruptcy, of loss of health or capacity, of external dangers such as thunder, accidents, and so on. The anxiety is as a rule only loosely attached to these ideas ; it is constantly attached only in the case of definite phobias, which do not form part of this neurosis. Disturbances of sleep are almost always present, insomnia and nightmare being very common. There is a general restlessness, " nervousness " or " jumpiness," and irritability, with a special hyperæsthesia for auditory sensations. Other chronic symptoms are dizziness ; vasomotor congestions with coldness of the extremities alternating with flushes of heat ; gastro-intestinal disorders, particularly nausea and diarrhœa ; cardiac and respiratory manifestations, such as anginal pain, oppression, and the periodic drawing of deep sighing breaths ; and various paræsthesias that may simulate rheumatic or neuralgic pains.

It will be seen that the disorder is of a strikingly protean nature, comprising very many forms of what is commonly called nervousness or neurasthenia. One has only to think of the numerous neurotics who suffer from chronic apprehensiveness, irritability, and the tendency to " worry " ; of the examples of the paræsthetic and

neuralgic type vaguely labelled neuritis; of the circulatory ones called pseudo-angina and vagal vertigo; of the gastric ones called dyspepsia or gastric erosion; and of such vague functional disorders as insomnia, stage-fright, vasomotor coldness or flushing, and so on.

Yet it is not hard to devise a common formula to cover all this apparently heterogeneous group of symptoms and syndromes, both mental and physical. They may all be described as exaggerations or distortions of the normal physiological accompaniments of *fear*, and the whole neurosis may be looked upon as a perversion of the fear instinct. The morbid nature of the condition essentially consists in the patient's suffering from an intensity of fear, or anxiety, that the external circumstances are inadequate to explain. It will further be noticed that the symptoms may be divided into two classes, one comprising examples of over-activity, the other examples of inhibition and under-activity; to the former class belong, for instance, tachycardia, tachypnoea, and polyuria, to the latter gastric inactivity, oppression of breathing with sighing, and so on. This remark applies to both the mental and physical symptoms.

B. DIAGNOSIS

In making the diagnosis of the condition two of its cardinal features should always be borne in mind: First, the great tendency there exists for symptoms referring to one or other system of organs to be so prominent as to dominate the clinical picture. When this is so, attention may be unduly attracted to the main symptoms to the

exclusion of the more accessory ones, and the general nature of the condition thus overlooked. It is rare for all the possible manifestations of the disorder to be so evenly present as was indicated in the sketch given above, localisation almost always taking place to a greater or less extent. This localisation depends partly on mental and partly on physical factors ; for instance, a patient with morbus cordis is more likely than another person to suffer especially from cardiac symptoms if he develops an anxiety neurosis. Many cases of asthma, angina, gastric and intestinal disorder, and so on, are in this way wrongly referred to the organic system apparently at fault, the primary neurosis not being recognised. A great number of organic diseases may be closely enough simulated by the neurosis to deceive the practitioner. I have, for instance, more than once seen the diagnosis of pulmonary tuberculosis made in cases of anxiety neurosis where the prominent symptoms were loss of weight, night sweating, and ill-defined respiratory disturbances. Secondly, the mental manifestations are often subordinated to the physical ones, and the observer may in this way be misled into overlooking the former. The undue prominence of the physical manifestations in comparison with the mental ones is a very characteristic feature of morbid anxiety as contrasted with normal fear, and particularly in the slighter and more chronic forms of the malady. This is a point not to be forgotten in trying to decide whether a given amount of fear is normal or excessive, as is also in this connection the point mentioned above concerning the disproportion of the reaction to the intensity of the exciting cause.

C. PATHOGENESIS

Further details of the symptomatology, ætiology, and pathology than can be given here must be sought in Freud's original writings; a good clinical description is also given by Loewenfeld.* Those interested in the manifold views that have been put forward concerning the pathology of the condition may be referred to a detailed discussion of them which I published some time ago.† Only the conclusions there reached will here be related, and those only briefly. Two views are currently maintained that seek to explain the condition on a physical basis, there being hardly any writer, except Prince, who holds a psychological theory of it. One postulates an *undue excitability* of the centres concerned in the regulation of the sympathetic nervous system and the functioning of internal organs, the other an *undue excitation* of the nervous system by impulses proceeding from these organs. All writers are agreed that we have to do with what is essentially a hyper-excitation process; some think that this hyper-excitation is a relative one, due to the action of normal stimuli on over-excitable centres, others that it is an absolute one, due to the action of excessively strong stimuli on normal centres. The failure to find any source for pathological stimuli in the internal organs in the majority of cases has led most writers to predicate the former view, although there is as complete an absence of definite evidence in favour of it as there is in the other case. Janet came near to the solution by pointing out the analogy

* Loewenfeld, "Die psychischen Zwangerscheinungen." 1904.

† "Papers on Psycho-Analysis," ch. xxvii. 1918.

between the phenomena of the neurosis and those of an aberrant discharge of visceral excitations the normal outlet to which is blocked, and Freud finally solved it by empirically discovering the source of the undue excitation, not where it had previously been looked for, in pathological disturbances of the internal organs, but in a more physiological region—namely, in excessive and unrelieved sexual tension. His conclusion may be stated as follows : Under certain circumstances sexual excitations arise that cannot follow their natural course of leading to either physical gratification or even to a conscious desire for such ; being deflected from their aim they manifest themselves mentally as morbid anxiety, physically as the bodily accompaniments of this. The precise relation, and mode of interaction, between the biological instincts of fear and sex cannot here be gone into, as we are not concerned with the general theory of the neuroses, but only with certain of their clinical aspects.

Everyone who has seriously investigated the facts has confirmed Freud's view of the pathology of the anxiety neurosis, and it may therefore be taken as a basis for our further discussion of the subject. Two factors are essential for the production of the malady, undue sexual excitation on the one hand, and inadequate relief of sexual tension on the other ; the more pronounced one of these factors is, the less pronounced need the other be to lead to the same result. The frequency of this combination in actual life accounts for the wide prevalence of some degree of the neurosis. The individual circumstances in which it is apt to arise need not be detailed here ; typical examples are : the over-arduous embraces of betrothed couples,

especially during long engagements ; the employment of certain harmful devices for the prevention of conception, particularly coitus interruptus—this being probably the most frequent single cause of the neurosis ; the abrupt introduction of girls or women to gross sexual experiences ; disproportion between desire and potency, or between desire and opportunity, a common state of affairs in both sexes after the age of fifty ; and, in certain circumstances, particularly when previous indulgence is suddenly given up, sexual abstinence. Any of these situations is the more likely to produce an anxiety neurosis if the suppression of desire is reinforced by undue repression of mental impulses.

It must, of course, not be forgotten that, in addition to the factors just mentioned, a considerable variety of adjuvant ones may also be operative, the chief being any natural cause of apprehension—illness or danger of a relative, fear of failure, and so on—fright, worry, grief, and mental strain. It is a fairly common occurrence for the outbreak of the neurosis to be determined by one of these factors, and even for the neurosis to disappear, either partly or altogether, when the influence of such adjuvant factors cease. Any or all of them, however, may be absent in a given case, whereas on the other hand the specific and essential factor is invariably present ; no anxiety neurosis will be found in a person whose sexual needs are being gratified. As with most other diseases, *e.g.* infective fevers, the specific agent may be present without causing the disease ; it all depends on the intensity or dosage. In such cases the added strain produced by an adjuvant morbid agent may be just sufficient to make

a previously latent neurosis manifest, and when it ceases the neurosis may once more become latent ; in such circumstances the casual observer is almost sure to make the mistake of inferring that this agent is the essential cause, in much the same way that fright was once thought to be an adequate cause of Graves' disease. The truth is that the influence of the specific factor lowers the person's resistance to the trials of daily life, so that he falls a victim to them when he otherwise would not. In many cases the action of any adjuvant factor is not necessary to evoke the disease, the intensity of the specific one being alone great enough to effect this.

D. TREATMENT

There are three ways of treating an anxiety neurosis, these being distinguished according to whether the treatment is directed against one or other of the three causes of the condition, the specific, the constitutional, or the exciting ; they will be considered in this order.

Specific.—Treatment of this cause is the only radical means of abolishing the neurosis. It consists in ascertaining and correcting the essential disturbance in the sexual life. If the possible situations are considered in which this type of disturbance may arise it will be seen that, roughly speaking, they fall into two groups, one of which is easily to be remedied by a few words of suitable advice, the other of which can hardly be influenced at all. In the former case the neurosis is soon cured by correcting the sexual disturbance, for instance, by inducing a patient to replace the practice of coitus interruptus either by unimpeded intercourse or by a more hygienic preventive measure.

In the second group of cases it is often out of the physician's power even to advise a correction of the sexual life, such as with many cases of enforced abstinence. The rule therefore is: whenever it is practicable the sexual deviation should be corrected; where this is impossible recourse must be had to one or both of the following two methods.

Constitutional.—It is a common experience to find that of two people equally exposed to the influence of the specific agents mentioned above, one will suffer from morbid anxiety to a much greater extent than the other. We are, of course, quite familiar with this occurrence elsewhere in general medicine, and are accustomed to explain it by invoking a more or less definite "constitutional" factor which is apparently operative in the one case and not in the other; the factor is usually, but not always, a hereditary one. In the anxiety neurosis we are also confronted with this constitutional factor, and fortunately its nature and mode of action can be defined. It differs from the specific factor in being purely psychological, further in having arisen early in the person's childhood life. It can be favourably influenced by an appropriate psychotherapeutic treatment that will enable the patient to endure with less ill-effect, and often with none at all, the given specific morbid situation.

In order to make this point clearer it will be necessary to forestall a little the discussion of anxiety-hysteria that follows in the next chapter. Two illustrative cases may be chosen to describe the matter most shortly: On the one hand, that of a man whose early mental development has been as healthy as possible, but who is suffering from an

anxiety state induced by the performance over several years of coitus interruptus (especially if carried out in the way most harmful to himself, namely, by attending purely to the *tempo* of his wife's feelings) ; on the other hand, a man whose early mental development has been such as seriously to affect his psycho-sexual life, so that he is unable to obtain gratification even when the external circumstances are favourable—for instance, he may be actually impotent—and who also develops an anxiety state from unrelieved sexual tension. The former represents a case of anxiety neurosis, the latter one of anxiety-hysteria ; in the one the primary cause is external to the mind, in the other it is internal. Between these two extremes all possible gradations are to be met with, the relative importance of the current physical disturbance and of the old psychogenic one varying from case to case. A common midway type is that of a man with harmful early influences of a certain strength, who does not suffer from anxiety symptoms provided that his sexual functioning is absolutely normal, but who does as soon as any deviation is made in this ; he is less able than a more healthy man to endure without ill-effect a deviation from the normal functioning, and may, for instance, suffer from various symptoms as the result of prolonged sexual abstinence. Now it is clear that with such a case as this, treatment might be directed towards either the physical or the mental aspect of the ætiology. The former is often the more easily remedied, but when for various reasons this is impracticable, one can have recourse to the more complicated line of treatment. The case is then regarded from the point of view of a psychoneurosis, instead of from

that of an "actual-neurosis," and the treatment becomes similar to that for hysteria. It is evident that when the therapeutic problem before one is definitely that of modifying pathogenic agents that date from early childhood life it is unwise to expect too much from the more superficial means of treatment detailed in the last chapter ; it is essentially a case for psycho-analysis.

Increasing experience has shewn that many more cases than used to be thought belong to this type of double ætiological factors, being, therefore, mixed cases of anxiety neurosis and anxiety-hysteria. There is certainly a striking variation in the extent to which different persons are affected by exactly the same physical stimuli, and this variation is found on investigation to be due to constitutional factors that have arisen in the course of early mental development, and which can be favourably influenced in a remarkable degree by appropriate mental treatment.

Exciting.—It was pointed out above that in most cases of anxiety neurosis there are, in addition to the specific agents, a number of adjuvant or exciting causes also operative, and that the extent to which the disorder is manifest, *i.e.* the amount of actual suffering, may largely depend on these. If they can be removed a considerable amelioration in the patient's state can usually be brought about, and not infrequently it can in this way be restored to practically his normal one. Such measures are : avoidance of excitement of any kind (not merely of occasions that might arouse sexual feeling, although these are naturally the most important), of worry, of tasks and situations that are apt to cause apprehension, change of scene and interests, a generally hygienic life, and so on. It is much

more satisfactory, however, to be able to bring the patient to such a state that he can with comfort face all the situations and difficulties of an ordinary life than to leave him in one in which he is free from suffering only on the condition of leading an artificially restricted life, and this desideratum can never with certainty be achieved except through one of the two radical lines of treatment indicated above.

Symptomatic.—Finally, the question of symptomatic treatment should also be mentioned. This proceeds along the usual medical lines, the treatment for nausea, diarrhoea, tachycardia, and so on, so that it need not be detailed here. Sleeplessness is often a troublesome symptom, and it is important to exhaust all other measures, such as hot baths, wet packs, etc., before resorting to hypnotic drugs. The same is true in an even higher degree of the use of opium to relieve anxiety, although one occasionally meets with instances of severe and prolonged acute attacks, especially those accompanied by depression, in which it is both justifiable and expedient. It is useful to advise the patient to undertake physical exercises, or work, even to the point of inducing fatigue ; this, however, in no sense applies to mental work.

BIBLIOGRAPHY

- Freud. "Sammlung," etc., Erste Folge, ch. v. and vii.
Jones, Ernest. "Papers on Psycho-Analysis," ch. xxvii.

CHAPTER IV

ANXIETY-HYSTERIA

THIS term was coined by Freud, in 1908, to denote certain neurotic states that bear the closest relation to both the classical hysteria and the anxiety neurosis ; they may be said to lie midway between these two conditions, with which we are already familiar. The cases of anxiety-hysteria are commonly grouped together in the text-books with those of other conditions the pathology of which is quite different, and are called either neurasthenic or psychasthenic. The manifestations of it comprise various phobias, together with the symptoms described in the last chapter as characteristic of anxiety neurosis. Not all phobias belong here, as is sometimes erroneously assumed, some for instance being manifestations of the obsessional neurosis, but it is true that the greater number do. Nine-tenths of all cases of so-called " nervousness " in children are of this nature, and the malady is also very common among adults, particularly women. The phobias, inhibitions, and other mental symptoms have quite a different pathogenic significance from the physical anxiety symptoms of the disease, as will presently be explained, and it is important to distinguish clearly between them.

A. RELATIONSHIPS

Relation to Anxiety Neurosis. — The relation between anxiety-hysteria and the anxiety neurosis was briefly indicated in the discussion of the latter. It may be characterised as follows: The existence of an anxiety-hysteria, or, more strictly speaking, of its causative agents, constitutes an important predisposing cause of anxiety neurosis; on the other hand, the existence of an anxiety neurosis, or, again, of the causative agents of this, constitutes an exciting or a precipitating cause of anxiety-hysteria when the specific causes of the latter are also present. The first condition renders a person more liable to an anxiety neurosis, and the occurrence of the latter tends to evoke a latent anxiety-hysteria. In this way a vicious circle is often established, and treatment has to be directed at two points. The reason why one condition influences the other has now to be explained.

In a case of anxiety-hysteria the process of repression, which is a normal accompaniment of childhood development, has not succeeded in bringing about the substitutions (sublimations) that characterise mental health and harmony, or at all events only to an imperfect extent. Deprived, at least partially, of this indirect means of gratifying the primary instincts, the person suffers more than the normal from any accumulation of sexual tension that may occur later, and will thus succumb more readily to an anxiety neurosis if a situation tending to give rise to it is present. There is a second, even more important, way in which an anxiety-hysteria predisposes to the occurrence of a later anxiety neurosis: in it various inhibitions are

formed, and these may hinder the ability to experience sexual gratification when the suitable opportunity presents itself, leading thus in men to psychical impotence, and in women to sexual anæsthesia ; this, of course, may be either relative or absolute. Gratification is here impossible for an internal, instead of an external reason, the result being the same—an anxiety neurosis. This latter mechanism, however, is by no means always operative in anxiety-hysteria, only when the inhibitions of the disorder directly affect the sexual sphere.

On the other hand, an anxiety neurosis tends to make manifest a previously latent anxiety-hysteria, or to intensify one that was already manifest. It acts in much the same way as the current, external difficulties of life do in the case of ordinary hysteria, except that it is a more specific, and therefore a more potent agent. The striving forwards of the sexual instinct is already impeded in a case of anxiety-hysteria by the various " fixations " that retard progress beyond the corresponding periods of childhood life, and on this account sublimation can take place only to an imperfect extent. The person is thus in a more precarious position than the normal, and can keep well only so long as everything goes right ; the sublimations together with regular sexual gratification may be enough to afford a free drainage of energy so that it is not necessary to construct any artificial channels of neurotic symptoms. When, however, sexual gratification is prevented by any of the causes that lead to the production of an anxiety neurosis, a damming up is brought about, and " regression " takes place towards the more infantile modes of functioning. These latter activities, after being distorted through

coming into conflict with the censorship of consciousness, constitute the symptoms of anxiety hysteria.

Relation to Conversion-Hysteria.—The relation between anxiety- and conversion-hysteria is as follows : Both are the result of a similar train of psychopathogenic agents, the roots of which lie in childhood, and they are thus merely different manifestations of the same malady. The essential difference between them is that in conversion-hysteria the productivity of the morbid tendencies leads to the creation of physical symptoms, by the process of conversion indicated in the chapter on hysteria, while in anxiety-hysteria its activity remains in the mental sphere, where it leads to the creation of specific phobias. It is true that in both there may be physical symptoms, paralysis being an instance in the one case and palpitation in the other, but these are quite dissimilar in kind. In conversion-hysteria the physical symptom is the external symbol of a group of ideas, whereas in anxiety-hysteria it is merely the expression, the necessary physiological accompaniment, of a given emotion ; in the former case the symptom has a precise mental meaning, in the latter it has none. Both kinds of symptoms are of psychogenetic origin in the sense that they are both ultimately due to morbid mental processes, but in conversion-hysteria these processes directly produce the symptom, whereas in anxiety-hysteria they produce only a certain emotional state, morbid anxiety, which happens to be invariably accompanied by physical manifestations.

B. PATHOGENESIS

The psychological structure of a phobia is highly complicated, and is exactly the same as that of any other hysterical symptom. In it are symbolised both a number of unconscious wishes and the corresponding repressing forces ; it is, in other words, a compromise-formation. The repressed sexual wishes, ultimately of infantile origin, manifest themselves consciously as anxiety, either intermittent or chronic, as was explained in reference to the anxiety neurosis. This anxiety, however, instead of being general, as in the latter condition, becomes localised on to a given idea which symbolises some sexual situation or other. The patient suffers from inhibition and anxiety in the attempt to perform a given act, such as that of crossing an open space, just as though he were a nervous person facing a sexual act to which he is not equal ; he is, of course, quite unaware of the meaning and source of his fear. The morbid fears are thus the expression of buried wishes ; with many of them this is popularly recognised, as is seen, for instance, in the jokes perpetrated about the maiden who before retiring looks under the bed to see if there is a man there, a practice she usually renounces after she has found the man of her choice. It is important to remember, however, that the ideational content of a phobia is hardly ever the same as that of the underlying wish ; the former stands in close associative connection to the latter and symbolises it, but it is rarely identical with it. In other words, the nature of the repressed wish cannot be discovered merely by taking a

phobia and replacing the fear by a wish ; the relationship of the two is much more complex.

The function of a phobia is fairly evident ; it is an inhibition that serves as a barrier to prevent an anxiety attack. Thus, someone who is subject to an attack of this sort when he stands at the edge of high places becomes afraid of high places, and even of the idea of them ; the fear guards him from the danger of ever exposing himself to an attack, but at the cost of a definite inhibition or renunciation. He becomes unable to do a certain thing, usually something easily done by a normal person. The natural evolution of the disease is in the direction of inhibition. As time goes on more and more inhibiting phobias get erected, like a chain of fortresses, and in many cases this process goes on to its logical termination of a complete safe-guarding against any possibility of attacks. When this happens the patient no longer suffers from anxiety or fear at all, but he is cut off from a considerable number of the normal activities of life, *e.g.* crossing streets, living in a town, entering a large room, and so on.

C. TREATMENT

The treatment of anxiety-hysteria is precisely the same as that of conversion-hysteria, with the addition that the anxiety itself has also to be treated. The reader is therefore referred to the chapters on hysteria and anxiety neurosis, both of which apply in every detail to the present condition. It may be said that morbid anxiety and "unreasonable" fears are more difficult to influence by suggestion than the other symptoms of hysteria. In the psycho-analysis of phobia cases there are a few points in

the technique used that differ from that of the treatment of conversion-hysteria, for which students of the subject must be referred to special sources.*

* For instance, Freud, "Wege der psychoanalytischen Therapie," *Internat. Zeitschr. f. ärztl. Psychoanalyse*, 1919, Jahrg. V., Heft 2.

BIBLIOGRAPHY

- Devaux et Logre. "Les Anxieux." 1917.
Freud. "Sammlung," etc. Erste und Dritte Folge.
Frink. "Morbid Fears and Compulsions." 1918.
Jones, Ernest. "Papers," etc., Ch. xxviii., xxix.
Prince, Morton. "Fear Neurosis," *Boston Med. and Surg. Journ.*, 1898.
Stekel. "Nervöse Angstzustände und deren Behandlung." 2^e Aufl. 1912.

CHAPTER V

NEURASTHENIA

A. NOSOLOGY

THE first, and all-important, point to grasp in this connection is that an extraordinary number of cases are commonly brought under this heading that properly belong elsewhere. Since Van Deusen first described and named this disease, over forty years ago, there has been a steadily increasing tendency on the part of the medical profession to include under it all sorts of nervous symptoms and syndromes provided they were not of an obviously hysterical order, until at the present day it comprises a conglomerate grouping of disparate conditions, the bonds between which are often of the filmiest description. It is hardly an exaggeration to say that for most physicians there exist only two neuroses, hysteria and neurasthenia.

Although this attitude is still represented by most text-books of general medicine, neurologists and psychopathologists have for many years evinced a growing dissatisfaction with it, and no authority on the subject now uses the term neurasthenia with the wide connotation that it popularly receives. Several serious attempts have been made to dismember this loosely knit group, and before any rational conception can be formed of neurasthenia itself it is essential that at least the following considerations be appreciated.

1. The diagnosis of neurasthenia is incorrectly made in many cases from the fact not being properly recognised that permanently mild forms of various psychoses are often met with in practice ; such are notably manic-depressive insanity (the cyclothymic variety) and paraphrenia (dementia præcox). If it is remembered that these two disorders alone make up over two-thirds of the cases of insanity in asylums, and that there are perhaps more patients suffering from them who are not confined in asylums than who are, the frequency with which this error in diagnosis must be committed will be evident.

2. The greater number of cases thought to be neurasthenic are really cases belonging to other forms of neurosis, which in ætiology, pathology, and consequently treatment, are quite distinct from this one. I refer particularly to cases of anxiety neurosis, anxiety-hysteria, and obsessional neurosis, conditions which are to be entirely separated from neurasthenia on the grounds just mentioned.

It is desirable to restrict the term neurasthenia to its primary meaning of an enfeeblement or fatigue neurosis, the cardinal symptoms of which are: an inordinate sense of mental and physical fatigue, "brain fag" and difficulty in concentration of attention and application to work, sense of pressure on the head, irritable spine, and various paræsthesias, particularly of the joints and muscles. Certain gastro-intestinal symptoms, such as constipation and flatulent dyspepsia, also occur, but are more closely related than are the other symptoms to complex psychogenic factors.

3. Even the syndrome just outlined is only to be regarded as truly neurasthenic, in contradistinction to

neurasthenoid, after it has first been shewn that it has not been secondarily produced by some other disease. It is well known, for example, that this clinical picture may be seen in various toxic states, notably as a sequel to influenza and enteric fever, and that it is quite common in the earlier stages of general paralysis. It is further important to remember that it may be a manifestation of an underlying hysteria, as Morton Prince first pointed out in connection with cases of multiple personality.

The term "neurasthenia" therefore, as used here, may be defined as a *primary fatigue neurosis*, i.e. one that is not merely a syndrome of another disease. It is probable that not more than one per cent. of the cases usually called neurasthenic are really of this nature. The true cases are much commoner in the male sex, and occur particularly among students and business men, at least so far as my experience goes.

B. PATHOGENESIS

Heredity.—It is unlikely that hereditary factors play any important part in its production, if only for the reason that the malady is often quite transitory in its appearance. In fact it is generally regarded as the best example of an acquired neurosis, and was thus separated by Charcot from "constitutional neurasthenia" and by Janet from psychasthenia, a condition which both these authors consider to be essentially hereditary. An acquired factor must therefore be sought for.

Toxic Origin.—Almost all writers agree that the main ætiological factors are of a physical order, but there is less consensus as to the nature of them. The analogy

with post-influenzal states naturally suggests a toxic agent, and the frequent occurrence of constipation one arising within the alimentary tract; this is probably, indeed, the most popular medical view of the complaint. It is, however, only one of the possible ways in which chronic fatigue may be brought about, and we therefore have no right to accept it as an explanation unless there is reason to think it more likely than the other possible ones. Against it may be urged the considerations that it is at best a speculative supposition, since no microbic toxins have ever been shown to be associated with the condition, that there is no analogy of any microbic toxin capable of producing a neurasthenoid state except for a short while—and then only when the toxin is as virulent a one as that of influenza or typhoid—and that the patients in question are often in perfect bodily health so far as can be determined.

Mental Strain and Over-work.—Many writers, dissatisfied with this vague supposition, have attributed the condition to mental strain and over-work, but not much has been gained by this attempt to discover a precise ætiology. There is little doubt that in some cases these are operative factors, for the condition may disappear when they are removed, only to re-appear when they return. They cannot, however, be the specific causes of neurasthenia, for in many cases they are not present at all, and even when they are it is rarely possible to trace much correspondence between them and the varying phases of the disease. In the same way it is also unlikely that mere sexual excess, provided that the functioning is of the normal kind, ever produces neurasthenia, though it is

commonly cited as an important cause ; it is evident that there are automatic physiological checks imposed in the way of sexual " excess " that prevent it from ever leading to serious harmful consequences.

Onanism.—For many years much importance has been attached to onanism in this connection, and according to Freud it is to be regarded as the specific cause of neurasthenia in the strict sense of the word. Medical opinion has always fluctuated widely as to the pathological importance to be attached to onanism. At the one extreme it has been thought to be responsible for spinal degeneration and insanity, as well as for a long list of other diseases ; as a reaction to these obvious exaggerations and misstatements it has been declared to be quite harmless. The truth probably lies between these two extremes. While there is no doubt that most of the terrors of masturbation are grossly exaggerated, there is reason to think that in certain circumstances too frequent repetition of the act is not altogether without harmful effect, and it is now becoming possible to define this with some approach to precision.

Freud's conclusion has to be amplified by the following remarks. The obvious disproportion between the incidence of cause and effect is explained by the consideration that onanism leads to neurasthenia only in certain circumstances, namely, when it is practised to excess as regards both frequency and length of time, and when it is accompanied by an unusually intense moral conflict. The resulting neurasthenia is only an exaggeration and fixation of the lassitude, fatigue, and general " slackness " that so commonly supervenes on a single act of mastur-

bation performed after a moral struggle. Much of the fatigue is the result, roughly speaking, of the expenditure of nervous energy in the overcoming of the moral scruples, a consummation which is usually achieved only after the accumulation of considerable sexual tension. It is always found that where these scruples are so intense as to be accompanied by neurasthenia there is present a deep underlying mental conflict (against, for instance, buried desires relating to sexual perversions or incestuous thoughts) which is symbolised in the phantasies that lead up to the performance of the act ; this is a factor of the greatest importance in connection with masturbation, far more than the mere physical functioning. The sexual act constitutes, owing to this conflict, an inadequate discharge of the accumulated tension, and is thus an unsatisfactory substitute for the normal one. Another reason for this also is the circumstance that with onanism there is an undue tax on the psychical energy of the person, in that he has to provide for himself—both physically and mentally—excitations that normally should come from without. In each act, therefore, he expends as much energy as both partners do normally, a process that easily lends itself to internal disharmony.

If properly inquired for, this ætiology will be found to be present in every case of neurasthenia. It must, of course, be remembered that the auto-erotic functioning known as onanism comprises several processes besides manual masturbation. In some cases of neurasthenia, for instance, there has been no masturbation, the pathogenic factor being excessive nocturnal pollutions. These pollutions, even when accompanied by exclusively disagree-

able sensations, represent sexual acts, and are probably always preceded by dreams in which repressed sexual wishes come, either openly or in a symbolic guise, to expression.

It should again be borne in mind that the conclusions just enunciated apply only to neurasthenia as conceived in the very restricted sense defined above. It is also plain that from this standpoint the action of the other ætiological factors mentioned, particularly strain and overwork, is not denied. They are merely relegated to the position of adjuvant or exciting factors, the significance of which can be described as follows : A person in whom the specific pathogenic agents are operative may or may not suffer from neurasthenia, this altogether depending on the intensity of them, but he is in any case less able to withstand reinforcing morbid agents, such as mental over-fatigue. In many cases, therefore, the presence of symptoms may be found to vary somewhat with the presence or absence of these adjuvant factors, the sum of noxa being increased by them to an intolerable degree.

In conclusion it may be pointed out that the ætiology of neurasthenia stands in almost exact contrast with that of the anxiety neurosis, as described in an earlier chapter. In the former the afferent excitations are deficient, and the efferent discharge excessive ; in the latter the afferent excitations are excessive, and the efferent discharge deficient. The treatment, therefore, is totally different in the two diseases.

C. TREATMENT

From the foregoing it will be seen that the treatment of neurasthenia can be clearly divided into radical and palliative ; the latter corresponds with the lines of treatment generally advocated in medical text-books.

The *radical treatment* consists of measures calculated to diminish or abolish the unsatisfactory auto-erotic habits of the patient. It is obvious that this can more easily be accomplished if the situation is such that they can be replaced by normal sexual functioning, the desirability of which is greater than in the case of a person not addicted to these habits, but even apart from this it is far from impossible. It is not necessary here to go into the various devices, mechanical or moral, that have been employed to wean patients from masturbation ; it may, however, be remarked that any which tend to increase his feeling of moral depravity or his fears as to the effect of the habits on his health are peculiarly unsuited to the present circumstances. These devices are well known to patients and to the laity in general, as are also their limitations when no substitute in the sexual life is available. It is important to realise that a refractoriness in yielding to them is generally due to the influence of buried mental complexes dating from early childhood, which can be affected by the psychotherapeutic measures described in the chapter on hysteria ; in obstinate cases, therefore, a course of such treatment is to be recommended, and will usually have the desired result.

The *palliative measures of treatment* are too familiar to need description in detail. They mainly consist in

rest from work and strain, removal of causes of worry and excitement (less important than the first-mentioned), change of scene and occupation, provision of agreeable interests, hydrotherapy, electrotherapy, attention to general health, and in severe cases a course of Weir Mitchell treatment. The most useful of these are the endeavours to arouse interest in new activities, which should be of an executive nature and not sedentary. They all suffer, however, from the drawback that they do not deal at all with the essential morbid factors, so that when the patient takes up again his old mode of life—often an unavoidable matter—the complaint is apt to recur. It is true that this does not always happen, and there are many cases in which it is possible to advise such an alteration in the daily routine and habits of life as to make all the difference to the symptoms. In slight cases the milder forms of treatment are often quite adequate ; in the more severe ones it may be necessary to advise a suitable course of psychotherapeutic treatment that will permanently free the patient from the morbid influences, or at all events from their effects. So long as these are left untreated the prognosis of the case must always be doubtful, for even if the patient recovers from one attack the next one may be longer and more severe, and the end of the case, especially if complicated—as it is apt to be—by graver neuroses, may be one of chronic nervous invalidism. The chief danger is the possible complication of an obsessional neurosis, to which many neurasthenic patients are specially liable.

BIBLIOGRAPHY

Beard. "A Practical Treatise on Nervous Exhaustion (Neurasthenia)." 1880.

Beni-Bard. "La Neurasthénie." 1908.

Binswanger. "Die Pathologie und Therapie der Neurasthenie." 1896.

Ferenczi. Contribution published in the *Diskussionen der Wiener psychoanalytischen Vereinigung*, Heft 2, 1912.

Freud. "Sammlung," etc., Erste Folge.

Proust and Ballet. "The Treatment of Neurasthenia" (Engl. Transl.). 1902.

Veraguth. "Neurasthenie." 1910.

CHAPTER VI

OBSESSIONAL NEUROSIS

THIS disorder, sometimes also called "compulsion-neurosis" (*Zwangsneurose*), is, like anxiety-hysteria, grouped by Janet under the heading of "psychasthenia," and is often to be found discussed under neurasthenia in medical text-books. As has been recognised for nearly fifty years, however, it constitutes a quite distinct neurosis, though it may sometimes be complicated by the presence of neurasthenic or hysterical manifestations. The diagnostic feature of the neurosis is the investment of various mental processes with a feeling of compulsion * (*Zwang*), as though the patient is being impelled against his will by an external force over which he has no control; he has, in fact, lost the normal capacity of inhibiting mental processes according to the needs of the moment.

A. SYMPTOMS

The symptoms are sometimes divided into the following four groups: (1) Motor (obsessive acts, impulses, *Zwangshandlungen*), (2) Sensory (obsessive hallucinations or sensations), (3) Ideational (obsessions, *Zwangsvorstellungen*), (4) Affective (obsessive emotions, particularly doubt and fear). The large group of tics ("habit spasms")

* One of my patients described this very well as a feeling of "mustness."

are probably also closely akin in nature. Familiar examples of motor "compulsion" in a slight degree are the obsessive impulses to touch every other rail of an iron fence as one walks past, to step on the cracks between the flag stones of the pavement or not to step on any of them, and so on. The person experiences a restless need in the given direction, and this is completely assuaged by performing the act, until a little later the same need recurs. Traces of these tendencies can be found in a large number of children between the ages of about nine and fifteen, including those who in later years are normal enough.

The term "obsession" or "obsessive idea" is, strictly speaking, an inaccurate one, for what occurs should rather be called "obsessive thinking" or "obsessive trains of thought." A typical example is the following, taken from an actual case: On having his attention called, in any way, to a given set of ideas the patient was obliged at once to discover a corresponding set that was as exactly opposite to the first as possible, then to find a counterpart to this set, and finally one that was the opposite of the third one; he constructed in this way a mental parallelogram, and would often have even to bisect this or find out other points mathematically related to it, all with corresponding sets of ideas. If the patient strives to suppress or omit one of the tendencies dictated by the compulsion, he is seized with more or less intense distress, and frequently by a sense of something sinister impending that will be consummated unless the compulsion be yielded to; for instance, one patient had to place his left hand behind his back every time he crossed the street, otherwise something evil would surely happen to his mother. The patient

is practically always aware of the uselessness, foolishness, or ridiculousness of his compulsive actions, but this makes absolutely no difference to the necessity for performing them. He has, in other words, complete insight into the pathological nature of the symptoms.

In severe cases the patient is so dominated by his obsessions and inhibitions that he may be quite unable to devote his attention to any of the duties of life. From a social point of view there is, apart from actual insanity, no more paralysing mental condition. The patient very rarely becomes insane, though he is often thought to be, and cases are to be found in most asylums. The mental torment is at times indescribably great, and the patient may not have a single moment free from his haunting obsessions, inhibitions, scruples, doubts, and fears. The malady is a very common one ; it affects men a good deal more frequently than women, and is most often found in unusually intelligent persons. For a further description of the clinical features the reader is referred to the excellent account given in Loewenfeld's monograph on the subject.*

B. PATHOGENESIS

The essential morbid feature of the neurosis is evidently the excessive psychical significance attaching to certain mental processes. This shews itself in two opposite ways, as compulsion and as inhibition. The patient is compelled to carry out a given trivial act, or a banal train of thought, with a feeling of urgent necessity, of absolute importance, that would be more appropriate with some-

* Loewenfeld, "Die psychischen Zwangsercheinungen." 1904.

thing on which his life depended. He might feel absolutely compelled, for instance, whenever he closed a door to touch it three times with his right thumb, or to do anything else equally absurd, and this with the same feeling of necessity as that with which a drowning man would clutch at a rope. On the other hand, such a patient may be thrown into an agony of indecision when faced with the most trifling dilemma, the action of his will-power being quite inhibited. For example, it is a matter of relatively little consequence which particular collar or tie a man puts on in the morning, but an obsessional patient may spend an hour in deciding the point, paralysed with doubt, just as if he were deliberating on a most delicate and vital decision.

The mental processes in question have somehow acquired an overcharge of importance, an excessive psychical accent, that does not properly belong to them. The problem therefore is, whence comes this excess of psychical significance? A detailed psycho-analysis of an individual example shews that the excess is due to a displacement from truly significant processes in the unconscious. This source might, indeed, have been suspected from a very typical feature of most obsessions, namely, the dissociation of them from the main conscious personality. The patient regards them as something forced on him against his will, not as any integral part of his conscious ego; he carries out obsessive acts not because he wants to, but because he must, because he has no peace until he does, because he cannot—except for a brief interval—control the impulse. As was insisted on previously, dissociation and lack of conscious control are eminently characteristic

of unconscious mental functioning, so that the feature in question is quite intelligible.

Through his psycho-analytic investigations Freud came to the conclusion that obsessive processes represent the return, in a distorted guise, of self-reproaches dating from childhood, and buried since then until the outbreak of the malady. They always refer to active sexual performances or tendencies. The psychogenesis of the condition differs from that of hysteria in a number of important respects ; it is much more complicated than that of the latter. There occurs early in life an exaggerated divorce between the instincts of hate and love, and the conflicts and antagonisms between the two dominate the most important reactions of the person. A fundamental state of doubt, an incapacity for decision, results from this paralysing conflict, and the compulsion is an over-compensation for this state of doubt. The patient oscillates between the two conditions of not being able to act or think (when he wants to) and being obliged to act or think (when he doesn't want to). The symptoms symbolise the conflicting forces. These are not, as in hysteria, fused into a compromise-formation, but come to separate and alternating expression ; one set of manifestations, therefore, symbolises the repressed forces, another the repressing.

C. TREATMENT

Practically all that was said on the subject of treatment in connection with hysteria also holds good here, so that the reader is referred to that chapter. Physical measures are almost altogether useless with the present

malady. The various forms of suggestion are much less effective in the treatment of the obsessional neurosis than in that of hysteria. There are several reasons for this. One is that the patients are apt to show very little susceptibility to suggestion or hypnotism. Another is the extraordinary productivity of the neurosis; new symptoms are created as fast as the old ones disappear, even within a few minutes, so that it becomes impracticable to try to remove them *seriatim* by means of individual suggestions. Speaking in general, it may be said that from the point of view of suggestion there are two kinds of symptoms in this neurosis, one that is absolutely refractory to any form of suggestion, and another that readily yields to it but is just as readily renewed.

On the other hand, the obsessional neurosis is particularly well suited to treatment by psycho-analysis, and some of the most brilliant successes of this method have been achieved in connection with it; the superiority of psycho-analysis over other methods is certainly much more striking with the obsessional neurosis than with hysteria. This becomes intelligible if the character of the two maladies is compared: the greater suggestibility and capacity of the hysteric for "transference" on the one hand, favouring the possibility of influencing the disorder by means of simple suggestion, and the greater complexity and purely mental nature of the obsessional neurosis on the other, lending itself to the unravelling procedures of psycho-analysis. There are some minor respects in which the technique of the method differs from that as used with hysteria, but it is not expedient in an elementary presentation such as this to enter into these details. It should be noted that

it is very desirable for such patients to be treated early in the course of the disease; they often refrain from seeking medical advice in the early stages, ascribing the manifestations to character anomalies rather than to a pathological disorder, and when it has been allowed to go on to a late stage the task of remedying it becomes much more formidable.

BIBLIOGRAPHY

- Brill. "Psychanalysis," Ch. iv.
Freud. "Sammlung," etc., Erste und Dritte Folge.
Janet. "Les Obsessions et la Psychasthénie." 1903.
Jones, Ernest. "Einige Fälle von Zwangsneurose," *Jahrbuch der Psychoanalyse*, Bde, iv. und v.
Loewenfeld. "Die psychischen Zwangserscheinungen." 1904.
Riklin. "Aus der Analyse einer Zwangsneurose," *Jahrbuch der Psychoanalyse*, Bd. ii.

CHAPTER VII

HYPOCHONDRIA AND FIXATION-HYSTERIA

A. NOSOLOGICAL RELATIONSHIP

THE relationship between the different neuroses is an interesting matter in itself, of which, however, only a few hints can be given here. It was pointed out in a former chapter that the anxiety neurosis and anxiety-hysteria are prone to co-exist, exerting a mutual influence on each other. Similarly it will often be found that after the psychogenetic superstructure of a conversion-hysteria or an obsessional neurosis is dissected away one may come upon an organic kernel of a neurasthenic nature.

The two neuroses considered in the present chapter have this in common, that they have an organic basis consisting in a peculiar, and probably hereditary sensitiveness of various parts of the body. The psychical superstructure that tends to get built on each, however, is widely different, leading in the case of hypochondria to paraphrenia (*dementia præcox*) and in the case of fixation hysteria to conversion-hysteria. Apart from this psychical superstructure, the site of the constitutional sensitiveness and also the symptoms themselves are quite different in the two disorders. In hypochondria the abnormal sensitiveness relates essentially to the internal organs, predominantly to the intestinal canal; whereas in fixation-hysteria

it is rather a question of the more external parts of the body, including the upper respiratory passages. In hypochondria the threshold to be passed by sensations emanating from stimulation of the internal organs, or even from their normal functioning, is unduly low, so that the person is more easily aware of any changes in them than is usually the case and is affected to a greater extent by any derangements of them. The result is a concentration of attention on the interior of the body, with the familiar proneness to valetudinarism. In the case of fixation-hysteria, on the other hand, the undue sensitiveness does not lead to preoccupation with the questions of health and disease, but it renders the person affected more susceptible to excessive reactions in regard to disturbing stimuli. The best example of this condition is the twin disorder known as hay fever and asthma, where the reactions to quite ordinary stimuli are so amazing to the normal observer.

B. PATHOGENESIS

In conditions so recently investigated as the two in question it is difficult to reduce the work hitherto accomplished to simple statements, but it may be said that the outstanding conclusion reached up to the present is that the peculiar sensitiveness characteristic of the conditions is of an erotogenic nature. The researches of the past few years, particularly those carried out by means of psychoanalysis, have made it very clear that the popular tendency to confine the conception of physical eroticism to the genital area is far from doing justice to the actual facts, and that the regions of the body capable of yielding erotic

sensations, of a varying degree, on appropriate stimulation—regions known as “erotogenic zones”—are both numerous and extensive. More striking still was the discovery that they are not even confined to the exterior of the body, the mucous membranes lining the lips, the urethra, and the anal canal having proved of unsuspected significance both in the development of the normal and in the pathogenesis of psychoneurotic symptoms. As was stated above, investigation of the two disorders here being considered points strongly to the constitutional basis residing in an excessive erotogenicity of certain areas of the body.

One of Freud's earliest hypotheses concerning the psychogenesis of conversion-hysteria was that the localisation of physical symptoms was favoured by a special somatic predisposition (*somatisches Entgegenkommen*) of the part affected, and this has been strikingly illustrated in the recent war, where the localisation was so often determined by a wound, sometimes even a trivial one, at the site of the subsequent conversion symptom. Fixation-hysteria appears to differ from the common conversion-hysteria in two respects: in the greater prominence of the part played by this somatic predisposition, and in the fact that the latter is always of an erotogenic nature, whereas this is not the case with conversion-hysteria.

C. TREATMENT

The treatment of both hypochondria and fixation hysteria does not differ in detail from that of hysteria as described above, so that there is nothing to add here.

The prognosis is certainly not so good as in conversion-hysteria, and there has not been long enough experience of treatment by the more radical methods to warrant any definite statements as to the permanent curability of the conditions.

BIBLIOGRAPHY

Ferenczi. "Hysterie und Pathoneurosen." 1919.

Freud. "Allgemeine Neurosenlehre." 1917.

Sadger. "Ist Asthma eine Sexualneurose," *Zentralbl. f. Psychoanalyse* Jahrg. i.

CHAPTER VIII

TRAUMATIC NEUROSES, INCLUDING WAR SHOCK

A. NOSOLOGY

It is plain that in here adopting an ætiological title to denote a group of neuroses we are having recourse to a mixed classification, a procedure which, however advantageous it may be from a practical point of view, always runs the risk of leading to some confusion of thought. It may, of course, happen that a given exciting cause, such as physical trauma, coincides with a characteristic pathogenesis and disease-course, in which event the resulting neurosis would have to be regarded as a distinctive condition. Experience, the final arbiter, seems, however, to indicate that this is not so in the group of disorders included under the present title, for while it is possible that the occurrence of a physical trauma may influence the course, and colour the symptoms, of most forms of neurosis—and, indeed, of the psychoses also, general paralysis of the insane being a well-known example—one can find nothing in either the symptomatology or the pathogenesis that is not also to be found with neuroses the history of which is free from the account of any such trauma.

Attention will be mainly confined in this chapter to the problems of war shock, as being of such pre-eminent current interest. It is not surprising to find that the

experiences of war have coloured and affected practically all forms of neurosis and psychosis, but it is perhaps surprising how little this has been the case with many forms. I have not heard, for instance, of any case of obsessional neurosis in which war experiences played any important part, beyond furnishing much suitable material for the tendencies already present, and I have studied two cases in which the effect of these experiences, even in the worst periods of the war, was strikingly little. Similarly I do not know of any example of chronic neurasthenia or hypochondria being engendered as the result of war experiences. By far the great majority of what may fairly be called war neuroses have been cases of hysteria, of either the conversion or the anxiety type, and most observers have commented on the relative rarity of the former among the officer class. We are faced, therefore, with the problem of determining how precisely the effects of war experiences—and just the same is true of other traumatic experiences in peace time—are related to the pathogenic agents characteristic of hysteria.

B. PATHOGENESIS

In the chapter on hysteria three main theories of the disorder were discussed, they being to the effect that the essential factors in the production of hysteria are external suggestion, shock, and repressed wishes respectively. As might have been expected from the vigour with which these views are held by their respective adherents, the experience of war neuroses has been considered to afford support to each one of the three, and if we were right in the conclusion reached above that there was some truth

in each of them it should not surprise us that this is the case.

Babinski and many other workers have been able to shew that a great number of the individual symptoms displayed by soldiers suffering from war shock have been, at least partly, determined by attention having been unduly directed to the part of the body affected, either by medical men or by wounds, and, further, that if counter-suggestion is used early and forcibly enough these symptoms disappear. But he has not been able to shew why only certain individuals responded to these suggestions, nor why those who did so responded to certain suggestions rather than to others. And already the transitoriness of the "cures" effected by means of suggestion has been proved in only too many cases.

The shock theory, on which treatment by means of re-educations is based, has found many adherents, and is probably the most widely accepted psychological explanation of the war neuroses. It seems so evident that the cause of the condition must lie in the shocks, injuries, and sufferings, bodily and mental, to which the soldiers were exposed in such rich measure that few have paused to note what problems still remain unsolved after making this simple observation. Such problems are: the small percentage of the total combatants thus affected, the fact that no correlation could be established between the incidence and the previous history of neurosis or "constitutional predisposition" as generally conceived, the extraordinary disproportion between the cause and effect—some of the worst cases occurred behind the lines without any exposure to trauma, while many of the most

frightful and devastating experiences were not followed by any neurosis—the reason for the precise nature of the symptoms, their localisation, course, etc., and the exact way in which the trauma produces its manifold results.

The psycho-analytical school laboured under serious disadvantages in attempting to formulate a theory of the nature and mechanism of war neuroses. It so happened that traumatic hysteria was the neurosis that had been least studied by psycho-analytic methods before the war. The opportunity to make any adequate investigation of cases was in all countries in the nature of things (length of leave, and so on) hard to get, and such investigations were sternly discouraged and wherever possible prevented by all the authorities. Further, psycho-analysts were accustomed to finding that the more manifest ætiological factors in the production of a neurosis, overwork, strain, etc., rarely cover the whole ground—or even the most important part of it—and to distinguishing clearly between the essential causes of a neurosis and the merely exciting factors.

Observations soon began to accumulate indicating the presence of at least some of the factors which psycho-analysis has revealed in the peace neuroses. It will be remembered that there are four components in the psycho-analytical theory of all psychoneuroses: that they are volitional in nature, that they are due to an intrapsychical conflict between the more and the less conscious trends of the mind, that they originate in infantile life, and that the essential nucleus is always sexual. The first two of these four principles were soon confirmed in great measure by

several observers, notably by MacCurdy and Rivers. During treatment of the cases the same underlying resistance against getting better was often not hard to note, even when the patient's conscious attitude was one of whole-hearted eagerness to return to the fighting line, a phenomenon comprehensibly rare. The same workers also lay stress on the part played by the conflict between the desire to do one's duty and the desire to save one's life from danger, and the attempts made, especially by officers, to repress the latter. MacCurdy and the present writer also called attention to the opportunity afforded by war experiences for the re-awakening of older, and often infantile, conflicts that in peace time could be buried or dealt with by sublimation, reaction-formation, and so forth, but which were operative in war in hindering the extensive readjustments that had to be gone through by every participator. In spite of the difficulties in the way of proper investigation of sufficient data, I have ventured elsewhere to sketch a theory of the nature and mechanism of war shock, which has been subsequently confirmed by workers in foreign countries, particularly by Abraham, Ferenczi, and Simmel. It is possible to reproduce only the outline of it here, since it raises some of the most obscure and only recently investigated factors in the psychology of the unconscious.

It is plain that the central problem in the genesis of war shock is that of fear, about which we have said nothing up to the present. Freud's work had shewn that we have been too generous in admitting the phenomena of fear into our conception of normal instincts, and he pointed out the necessity for distinguishing more clearly between the

normal manifestations of the fear instinct ("real" fear : sensory and motor preparedness, with, on occasion, suitable conduct) and morbid ones ("developed" fear or "morbid anxiety" : disproportionate reaction, excess of somatic accompaniments, and paralysing inhibition, as described in the chapter on the anxiety neurosis). He had found that what may be called the morbid manifestations of fear always stood in the closest relation to repressed sexuality, which therefore raised the question of the relation of this to the morbid aspects of the "real" fear in soldiers. Actual observation, however, did not permit of any correlation being established between the two, or only in certain cases, but on the other hand it was found that the occurrence of war neurosis was closely related to a psychological component that is not generally classed as sexual—namely, self-love. Of late years, particularly as the result of researches on dementia præcox, much attention has been paid to the question of self-love, and it has been found that it is genetically related to the usual form of sexuality (*i.e.* hetero-erotism), being in all probability the ultimate source of the latter. The earliest form of infantile love is self-love, or "narcissism," and the passage from this stage of development to later forms of love is often far less complete than is generally imagined. The source of the morbid fear present in most cases of war neurosis appears to be repressed narcissism, and it is even possible to predict from this knowledge which men will be more liable to suffer from war shock or any similar trauma.

C. TREATMENT

During the war any medical views as to the most desirable modes of treatment for the neuroses that occurred had to be sternly subordinated to the exigencies of the situation, and there is little point in going over now the ways in which human material was recklessly wasted through the lack of knowledge of clinical psychology so widely displayed at that time. The cases seemed to fall into two broad groups according to their severity, and interest only remains in one of these. The one type tended to recover almost spontaneously after a short space of time in a favourable environment, and of course responded gratefully to almost any form of treatment. The other, much more refractory, type differed pathologically in that the experiences not only set up a conflict between the non-sexual ideals of the ego on the one hand and repressed narcissism on the other, but also revived other tendencies to neurosis in the unconscious, conflicts of a kind more nearly resembling those with which we are familiar in the case of ordinary hysteria ; prominent among these are repressed incestuous, sadistic, and homosexual complexes. In other words, the longer a case of war neurosis persisted the more did its pathology approximate to that of the hysteria of peace, so that one might speak of the transformation of a " war neurosis " into a " peace neurosis." The half-conscious motive of wishing to avoid a return to the perils and discomforts of war have now been replaced by those to do with gratuities, pensions, and other forms of support, which sometimes get connected

with the unconscious wish to revert to a more infantile relationship towards life.

At present most forms of psychotherapy are being employed in regard to these cases, and perhaps it is premature to say anything definite in regard to the durability and completeness of the cures achieved by the different methods. It is observable that there is a decided tendency among those in charge of such cases to become increasingly dissatisfied with the simpler modes of treatment, and the passage over from the ranks of the hypnotists to those of the psycho-analysts has of late been very pronounced. It is perhaps worth insisting that, even when it was impracticable to carry out a regular psycho-analysis, a knowledge of the subject has proved invaluable in dealing with these patients, along whatever line. For a discussion of the respective methods of treatment the reader is referred to the chapter on hysteria.

BIBLIOGRAPHY

- Eder. "War Shock." 1917.
 Jones, Ernest. "War Shock and Freud's Theory of the Neuroses," *Proceedings of the Royal Society of Medicine*. 1918.
 MacCurdy. "War Neuroses." 1918.
 Myers. "Contributions to the Study of Shell Shock," *Lancet*, 1915, 1916.
 Read, Stanford. "A Survey of War Neuro-Psychiatry." 1918.
 Rivers. "The Repression of War Experiences," *Lancet*, 1918;
 "War Neurosis and Military Training," *Mental Hygiene*, vol. ii.
 Roussy and Lhermitte. "The Psychoneuroses of War" (Engl. Transl.). 1918.
 Smith, Elliot and Pear. "Shell Shock and its Lessons." 2nd Ed. 1919.
 Symposium by Abraham, Ferenczi, Freud, Ernest Jones, and Simmel. "Zur Psychoanalyse der Kriegsneurosen." 1919.
 See also the reviews of the extensive literature in *Mental Hygiene*, *Revue Neurologique*, *Zeitschr. f. d. ges. Neurol. u. Psychiatrie*.

CHAPTER IX

PROPHYLAXIS OF THE NEUROSES

THE great progress that has been made of late years in our knowledge of the nature and causation of the neuroses has proved of even greater value in regard to prophylaxis than to remedial treatment, and a stage has already been reached where it is not an exaggeration to say that with due care the development of a neurosis can in most cases be definitely prevented. The matter is evidently of special importance to the general practitioner, not only because the opportunities and responsibilities in this direction lie almost entirely in his hands, but also because many of the necessary steps, and fortunately the most important ones, do not depend for their application on any very technical knowledge of clinical psychology.

The three chief aspects of this question are those concerning *individual hygiene*, social organisation, and education respectively. Touching the first of these, little remains to be added to what has already been said. As regards the "actual neuroses," the specific factors discussed in connection with them should be avoided so far as possible, particularly by those persons predisposed by errors of development, which often betray themselves in minor manifestations often not definitely morbid (oddities of

character, "inadequate" emotional reactions, and so on). Persons who already shew a tendency to the development of a "psychoneurosis" need to be warned against exposing themselves to the action of external, adjuvant factors, and to situations for which they are ill adapted. These cannot be specified in detail, not only because they vary from case to case, but also because the understanding of many of them presupposes a considerable knowledge of the given individual's particular psychogenesis, with a corresponding appreciation of the weak places in his resistance.

A simple example may be chosen, of a general nature. In spite of the prevailing view to the contrary, it is always a hazardous proceeding for any neurotic person to marry, and the advice frequently given to marry as a cure for the neurosis is in most cases devoid of any scientific justification. The potentialities of married life may well at times prove such as to demand a robust and balanced nervous and mental constitution to endure them without harm, and a neurotic, whether man or woman, is taking a considerable risk in facing the latent possibilities of psychical trauma that pertain to married life. The outcome may be favourable if the concatenation of circumstances is propitious, it is more often unfortunate or even disastrous, and in any case it is extremely difficult to predict. This statement, of course, applies only to those patients who have not undergone a suitable treatment.

Adequately to discuss the subject of *social organisation* in its relation to the neuroses would necessitate a book in itself, and I shall confine myself here to one or two general remarks. It is becoming increasingly evident that the

experience gained¹ by the study of medical psychology will have in the future to be taken into serious account by those who wish to form sound judgements on various social problems. Our knowledge is perhaps not yet ripe enough to lend itself to ready generalisations, but there is no doubt that the medical psychologist is compelled to recognise the significance of certain aspects of these problems that are only too commonly ignored. He can already, for instance, definitely point to the injurious effects of unhappy marriages on the future development of the children concerned (a matter that has an obvious bearing on the problem of divorce), to the seriousness of protracting indefinitely a life of sexual abstinence—particularly in the case of persons of a certain constitutional type—to the illusoriness of regarding marriage as necessarily offering a cure for the woes of celibacy (the one state is for many people as hard to bear as the other), and to the impossibility of enforcing without grave harm a uniform moral standard and mode of living, to demand a uniform and inelastic standard in the fields of emotion and instinct being as preposterous and as untrue to the considerations of reality as it would be in the field of intellect.

The prophylactic results most readily to be achieved at present are those in regard to *education*,* for the conclusions dictated in this connection by medical psychology are both important and easy of application. I shall select two of these for special comment, namely, the importance of preventing precocious sexual excitation and undue

* For further details on this subject the reader may be referred to chapters xxxiv. to xxxvii. of my "Papers on Psycho-Analysis."

repression respectively. As regards the former, the chief points that issue from psycho-analytical investigations are that this occurrence is possible in ways that are commonly overlooked, and that it is a matter of unsuspected significance for the child's whole later development. It has been found that pleasurable sensations definitely charged with sexual feeling can be aroused at a much earlier age than is generally recognised, and, occurring as they commonly do in relation to the parents—at a period long before the child knows anything about the cardinal distinction between relatives and other people as objects of sexual interest—they often pave the way for later unconscious fixations of feeling and moral conflicts of central importance for the development of a neurosis. Such sensations may be excited through over-fondling and extreme caresses on the part of a parent, through perverted scrupulousness in matters of cleanliness—both of which are often the consequence of neurotic tendencies in the mother—through allowing the infant to develop the habit of stilling all his ungratified desires and deadening all his discomforts in the satisfying rhythm of buccal activities; through his being allowed to sleep together with older children or grown-up people at an age when this is thought not to matter; and, perhaps commonest of all, through his overhearing or actually witnessing conjugal embraces, the meaning of which may escape him at the time though the impression produced on his mind is lasting. In all such matters the physician is able, if he realises the importance of them, to give simple but valuable advice to the parents, which would often have the result of avoiding years of later misery. To take an example: it is possible

to relieve many cases of "night-terrors," which frequently are the first indication of a serious neurosis, by merely attending to the sleeping arrangements from this point of view.

The second conclusion referred to is based on the knowledge that excessive reactions to sexual happenings in early life, in the form of undue sense of guilt, terror, shame, and remorse, play a most important and indeed an essential part in the development of psychoneuroses. This is one of the most cogent reasons why enlightenment on such topics should proceed along different lines from those now customary. The rules for the guidance of the parent in this matter are perfectly simple. No enlightenment is in most cases necessary, until the child spontaneously demands it, and even then only so far as he does demand it, due regard of course being also taken for his capacity of understanding. With most normal children the process will gradually be passed through between the ages of three and six. After this age it is usually too late, for if the child has been rebuffed he will certainly by then have formed his own conceptions and phantasies on the subject unknown to the mother, and, although these are usually buried and forgotten within the next few years, they continue to exert indirectly an important influence on the development of his mind. Under no circumstances should the child ever be lied to in such matters, or the subject too obviously evaded. A healthy, natural attitude should be instilled into his mind from the first, not so much by the mother's inculcating positive tendencies as by her avoiding manifestations of undue reprobation that are apt to implant too strong a sense of sinfulness.

Simple as these rules are, I am fully cognizant of the difficulties in the way of getting them appreciated. Almost the only open expression of opinion that can be elicited on the topic of sex is the one that lays stress on the danger and sinfulness of thoughts, let alone acts, concerning it. The epidemic of "sexual enlightenment in the schools" that is at present sweeping over most civilised countries is unduly preoccupied with the single task of warning children, *i.e.* with the negative instead of the positive aspects of the problem. It is to be anticipated that any beneficial results of this movement will be completely outweighed by the harmful ones, and as a weapon in the fight against the neuroses its possible favourable influence will be negligible. Neurosis is the price, and it is far from being the only one, that society pays for its hypocrisy, for its intellectual and moral obliquity.

Finally, a word may be said on a matter that is often under the parents' control, namely, the danger of bringing up a child in adult company. Numerous observations, made by Brill and others, have shewn that the large majority of only children become in later years neurotics, and the same applies to children that are selected for undue favouritism on the part of the parents. The natural and only healthy environment for a child is the companionship of other children, and if circumstances render this impossible at home other measures should be taken to ensure it.

BIBLIOGRAPHY

- Brill. "Psychanalysis," ch. xi.
Freud. "Sammlung," etc., Zweite Folge.
Jones, Ernest. "Papers on Psycho-Analysis," chapters xxxiv.-xxxvii.
Von Hug-Hellmuth. "Aus dem Seelenleben des Kindes." 1913.

CHAPTER X

MENTAL TREATMENT OF CONDITIONS ALLIED TO THE NEUROSES

A SHORT summary may be given of the application of mental therapeutics to other conditions than the neuroses. These will be divided into psychoses and a miscellaneous group comprising various habits and aberrations.

A. PSYCHOSES

Paraphrenia (Dementia præcox)

Little can be done in this disease except in the earliest stages. The most amenable form is the catatonic one, and the least the hebephrenic. Hypnotism may be beneficially used in some cases for such purposes as the induction of sleep, the influencing of the taking of food, and so on. Much work has also been done in this field by means of the psycho-analytic method, and, thanks to the investigations of Jung and his pupils, considerable light has been thrown on the psychogenesis of the condition. It is often possible to remove certain symptoms by the application of psycho-analysis to unravel them, much as is done in the case of the neuroses, and to improve the patient's general state to a considerable extent. In exceptional instances the patient may be restored to apparently normal health, certainly to full activity; it is clear, however, that one

cannot pretend to have thereby cured the disease itself, and there is always the danger that the patient will relapse at some later date. It further seems likely that the effect of the analysis may occasionally be to worsen the patient's condition, particularly when applied in unskilled hands without due precaution, but it must be remembered that the malady is a desperate one, where it is therefore justifiable to run a certain amount of risk. It may in any case be said that, in spite of the unfavourable material present, psycho-analysis offers a more hopeful possibility in this disease than does any other form of treatment.

Manic-Depressive Insanity

A much more promising scope for therapeutics is offered by manic-depressive insanity, particularly in the cyclothymic variety, where, as was pointed out above, the erroneous diagnosis of neurasthenia is often made. In the acute stages of either exaltation or depression practically nothing can be done by any form of mental therapeutics, so one has to wait for an intermittent phase. Investigations by Abraham, Maeder, and myself have shewn that many cases of this nature can be beneficially influenced by means of psycho-analysis to a remarkable extent, far more than might have been thought likely. Abraham in particular has thrown much light on the psychological structure of the disease; he lays especially stress on the resemblances between it and the obsessional neurosis. On the other hand, Brill has pointed out that some cases presenting a perfect clinical picture of manic-depressive insanity prove on analysis to be really cases of anxiety-hysteria, and this I can fully confirm from my

own experience. It would seem as if cases of manic-depressive insanity may be divided psychogenetically into two fairly distinct groups, the structure of which is akin to that of the neuroses and of paraphrenia respectively. In the former case a fairly good prognosis may be given as to the result of psycho-analytic treatment, which in favourable instances, as I know from personal experience, may bring about a complete and lasting cure. In the latter group, on the contrary, I have never succeeded in curing any patient, though much may be done to render the attacks less severe and less frequent. It should be added that up to the present there is no means known of distinguishing between the two groups except by conducting a psycho-analysis of the case.

Epilepsy

The question of epilepsy is difficult to discuss in this connection on account of the present uncertainty as to the nosological status of the disease. It is considered that several quite different conditions are now included under this term. Probably some of these can be therapeutically influenced and others not. At all events it is known that mental treatment can greatly benefit, and even cure, a certain number of cases where the diagnosis of epilepsy has been made by experienced authorities. This has been accomplished by means of hypnotism, re-education, and psycho-analysis, but from the complex nature of the disorder it is to be expected that it is the most radical methods which hold out the best prospects of relief. It has been known for some years that perfectly typical epileptic fits may occur in conditions that are of purely psychogenic

origin,* and it would be a great gain if we could clinically distinguish these from the graver forms where mental therapeutics can accomplish nothing even in the early stages ; much work has already been done, by Maeder, Sadger, Stekel, and others, in the direction of defining the characteristic psychogenesis of the various forms. The most fruitful work on the psychopathology and treatment of epilepsy has been accomplished in America, by Pierce Clark and MacCurdy, who have shewn that even fairly advanced cases are surprisingly amenable to psycho-analysis. It need hardly be said that mental therapeutics is of no avail in cases where mental deterioration has set in.

B. VARIOUS HABITS AND ABERRATIONS

Alcoholism

Mental therapeutics is practically useless in cases of alcoholism where there is a definite psychosis present, and it is highly probable, in spite of the popular view to the contrary, that the so-called alcoholic psychoses are really instances of paraphrenia, epilepsy, and other conditions, that are merely complicated by the co-existence of alcoholism ; this remark does not, of course, apply to the acute toxic states, such as hallucinosis, Korsakoff's psychosis, and so on.

Suggestion has been extensively employed in the treatment of the milder forms of alcoholism, and often with

* See a study on this subject in my " Papers on Psycho-Analysis," chapter xxv.

good results. There seems, however, to be a remarkable variability amongst alcoholics in their susceptibility to this form of treatment, and the cases might fairly be divided into those that respond very well and those that do not respond at all, the latter unfortunately comprising by far the greater number ; further, the more intractable types of alcoholism, such as dipsomania, are not easily influenced in this way. There is thus a great uncertainty in the prognosis of cases submitted to treatment by suggestion, and, as will readily be understood, there is always of necessity an uncertainty as to the future prognosis even in the cases that have been benefitted, for no attempt has been made to deal with the cause of the morbid tendency.

By means of psycho-analytic investigation Abraham, Ferenczi, Freud, and others have shewn that the drinking habit is determined by complex but precise mental factors, the psychology of which is now well understood. Just as in the neuroses, there are accessory factors as well, such as temptation, opportunity, etc., but no one will become an excessive or uncontrollable drinker from these alone. The essential morbid agent is probably always repressed homosexuality, in both sexes ; the poison acts by breaking down to a greater or less extent the inhibitions that prevent the affects of this tendency from entering consciousness, and once the person has become accustomed to the temporary sense of well-being induced in this way he finds it exceedingly hard to forego. Psycho-analysis, by laying bare and translating into consciousness the roots of the morbid tendency, renders superfluous the recourse to the artificial aid of alcohol, and so rids the person of this necessity. I have obtained several gratifying and lasting

results from this method of treatment—though, it is true, never in advanced cases—and consider it superior to any other in radically altering the mental situation so as to give the patient control over his aberrant tendencies.

Drug Habits

Similar remarks apply in the case of the various drug habits, where also repressed homosexuality plays a highly important, and perhaps the essential part. The action of the drug deadens the effects of buried mental conflicts, the distress of which returns in a compelling manner as soon as the drug is abstained from. A powerful effort of renunciation, aided by various suggestive influences, may succeed in combating the need for the drug, but that the underlying tendencies are still present is shewn by the well-known precariousness of the results obtained in this way. Psycho-analysis, on the other hand, as in the case of alcoholism, leads to an improved mental harmony, and thus yields correspondingly better therapeutic results.

Homosexual Inversion

Homosexual inversion, on account of its great frequency and the mental and social suffering it entails, has given rise to considerable discussion as to the possibility of influencing it therapeutically. Much hope, for instance, was built on the early work of Schrenk-Nötzing with hypnotism, but more extended experience has led only to disappointment in this direction. Most authorities on the subject consider that the condition is definitely inborn and not amenable to therapeutic influence. The investi-

gations by means of psycho-analysis have led to more hopeful conclusions. They have established two matters in regard to the condition : first, that it is a complex product of several factors, and not a simple manifestation of a congenital abnormality, as is generally thought ; and secondly, that the psychogenesis of it is not always the same, there being certain fairly well-defined types. It has further been shewn, first by Sadger, that the psychogenetic factors may be successfully influenced by means of psycho-analysis, so that homosexuality is no longer to be regarded as an absolutely irremediable state. From my own experience I would say that it is much harder to influence than most cases of neurosis, that an even longer treatment is necessary, and that the different types do not respond equally to therapeutic efforts. In giving a prognosis of an individual case, therefore, one should be chary of too great optimism, the variation between different cases being so considerable. There are, in the first place, all possible degrees of homosexuality, from the trace of it that is present in all normal people to the extreme form where the opposite sex fails to exert any attraction at all. Then, the persons afflicted differ remarkably in their attitude towards their state, and in the wholeheartedness with which they desire to change it. Many are quite reconciled to it, are, indeed, proud of it, and will come for treatment only out of deference to some social complication or a desire for offspring. Lastly, as was remarked above, the types themselves differ in the degree of refractoriness they shew, this being, for instance, greater in the cases where both the sexual aim (attitude) and the object are inverted than in those where only the latter is. All these factors, as well as the

other general ones, have to be taken into careful consideration before committing oneself to a prognosis as to the result of treatment. One can, however, safely say that no form of treatment holds out the prospect of radically changing the mental attitude that the psycho-analytic one does.

Sexual Perversion

From the point of view of psychogenesis the numerous forms of sexual perversion may be divided into two groups. According to Freud, all children shew rudimentary traces of what when fully developed would be termed perversions. Normally these undergo a process of repression leading to a translation into other forms of activity. As an example we may cite the diffuse extent of the zones of excitation in the young child, which always includes the excretory orifices ; in later years these zones become restricted so as to comprise little more than the genital organs themselves, especially in men. Now one group of perversion arises as the result of a complicated distortion in the psycho-sexual development through the formation of abnormal associations, etc. ; instances of this are fetichism, bestiality, and necrophilia. Those belonging to the other group consist of a fixation and exaggeration of a single biological component of the instinct, such as is the case with sadism, masochism, exhibitionism, and so on ; even with this latter group, however, it is found that the fixation is not altogether due to the inheritance of a specially strong tendency corresponding with this component, but is brought about as the result of an interaction between the latter and various external influences. The exceedingly

close relationship that Freud has shewn to exist between psychoneurotic symptoms and sexual perversions, the one representing the negative, the other the positive side of the same impulses, makes it intelligible that a method devised for the treatment of the former condition should also be of service in dealing with the latter. It is, however, a matter on which I cannot speak from personal experience, for up to the present I have not had an opportunity of treating any case of sexual perversion itself. I have, on the other hand, obtained satisfactory results in many cases of neurosis complicated by sexual perversities, where psycho-analysis has made it possible for the patient to control these and to guide into other directions the energy appertaining to them. Suggestion is notoriously inefficacious in these conditions.

Criminality

Criminality is also a matter on which no very definite statements can be made from the therapeutic point of view. For obvious reasons, psycho-analysts have not occupied themselves immediately with the treatment of criminals (with the exception of kleptomania), but Stekel, Wulffen, and others have elucidated the origin and significance of many criminal tendencies in neurotic persons. It has been shewn that the impulses usually take their origin in the unconscious, that traces of them are widely present in the normal, and that they are closely intertwined with the other aberrant tendencies that more directly concern the therapist. The field is therefore a promising one for psychopathological research, and it is to be anticipated that further work along these lines will

contribute much to our understanding and control of criminality, especially from a prophylactic point of view.

Miscellaneous Mental Anomalies

We have last to mention a miscellaneous group of conditions that are not usually regarded as diseases even in the wider sense of the term, but which are of very considerable social importance. I refer to various character anomalies, reactions, and traits, which when developed beyond a certain point can lead to much suffering and also seriously impair the usefulness of the person concerned. Some of their effects are social friction, marital incompatibility and unhappiness, inability to live harmoniously with other members of the family, difficulty in adjusting oneself to one's work or to the various duties and exigencies of life, inability to become reconciled to inevitable situations, ill-temper and irritability, excessive grief, disappointment, or sense of failure, and so on ; in a word, a series of mental situations that may best be summed up under the term "unhappiness."

The character abnormalities that lead to these results take their origin in childhood tendencies that have been insufficiently controlled and modified in the course of development, and which, though now unconscious, produce an inner disharmony in the person's mind and conduct. Such cases do not commonly present themselves for medical treatment unless they are complicated by a definite neurotic state, but a medical psychologist has many opportunities to investigate conditions of the kind. Mental therapeutics can often achieve very grateful results in these

cases. They lend themselves with especial appropriateness to treatment by means of psycho-analysis, and experience has shewn that a careful disentangling of the person's innermost tendencies is often of the greatest benefit in giving him a better control over them, with a correspondingly heightened capacity for adjusting himself to the necessary situations of life.

BIBLIOGRAPHY

SECTION A

Abraham. "Ansätze zur psychoanalytischen Erforschung und Behandlung des manisch-depressiven Irreseins," *Zentralbl. f. Psychoanalyse*, Jahrg. II.

Brill. "Psychanalysis," chapters vi. and vii.

Clark, Pierce. Numerous articles on epilepsy in the *New York Medical Journal*, *Interstate Medical Journal*, and the *Medical Record*, 1915, 1916. "Clinical Studies in Epilepsy." 1917.

Ferenczi. "Contributions to Psycho-Analysis," chapters v. and xi.

Freud. "Sammlung," etc., Dritte und Vierte Folge.

Jones, Ernest. "Papers on Psycho-Analysis," chapters xxv., xxvi.

Jung. "The Psychology of Dementia Præcox" (Engl. Transl.). 1909. "Der Inhalt der Psychose." 1908.

Maeder. "Sexualität und Epilepsie," *Jahrbuch der Psychoanalyse*, Bd. I.

SECTION B

Numerous articles, particularly by Ferenczi and Sadger, in the psycho-analytical journals.

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